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Manitoba Medical Association
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Report of
Nominating Committee
Page 372

STACKS

Vol. 33

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No. 7

Medicine:

Immediate and Long Term Management of
Chemical Burns of the Oesophagus,

C. B. Schoemperlen 351

Heredity and Environment 356

Cardiology:

Cardiac Pain, B. H. Lyons 358

Anaesthesiology:

Abstract—Cardiac Resuscitation 362

Surgery:

Surgical Treatment of Carcinoma of the
Laryngo-Pharynx, Harry Lister 363

Association Page: M. T. Macfarland 364

Fugitive Pieces:

More About Mephibosheth and Vulcan,
J. C. Hossack 369

Letter to the Editor:

Three Cheers for Our Side 372

Medical History Club:

The Chronicles of the Medical History Club,
J. C. Hossack 375

Winnipeg Medical Society:

Report of Meeting 381

Committee Reports, 1952-1953 381

College of Physicians and Surgeons:

Registration Committee 393

Executive Committee 393

Department of Health and Public Welfare:

Communicable Disease Report 399

Mortality Statistics 399

Detailmen's Directory 400

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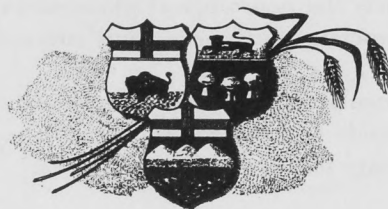
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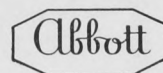
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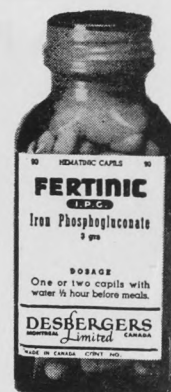
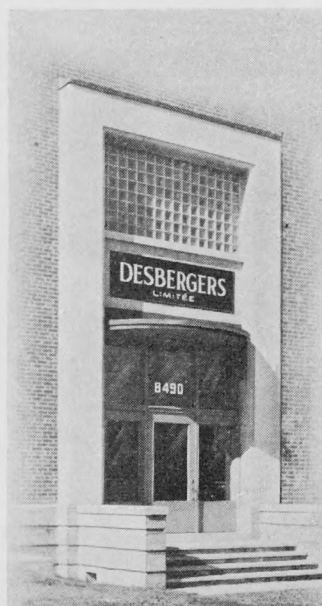
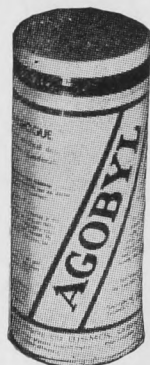
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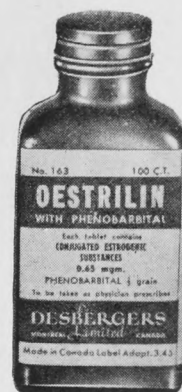
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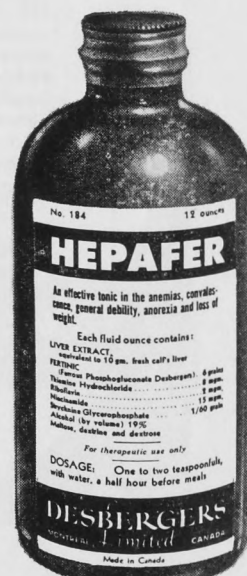
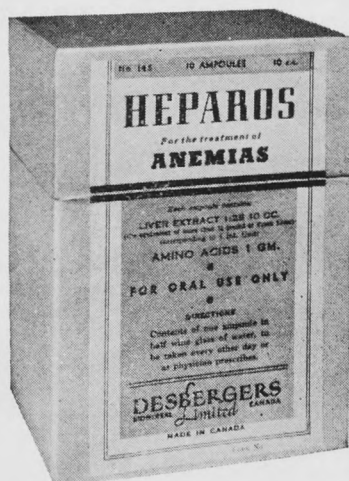
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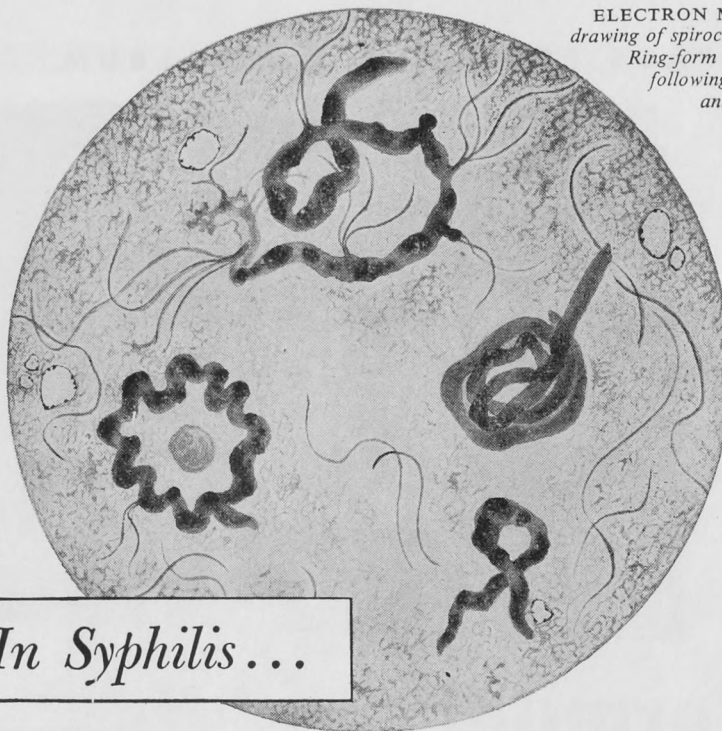
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Curtis, A.C., Kitchen, D.K., O'Leary, P.A., Rattner, H., Rein, C.R., Schoch, A.G., Shaffer, L.W., and Wile, U.J.:
Penicillin Treatment of Syphilis, *J. A. M. A.* 145: 1223-1226, April 21, 1951.

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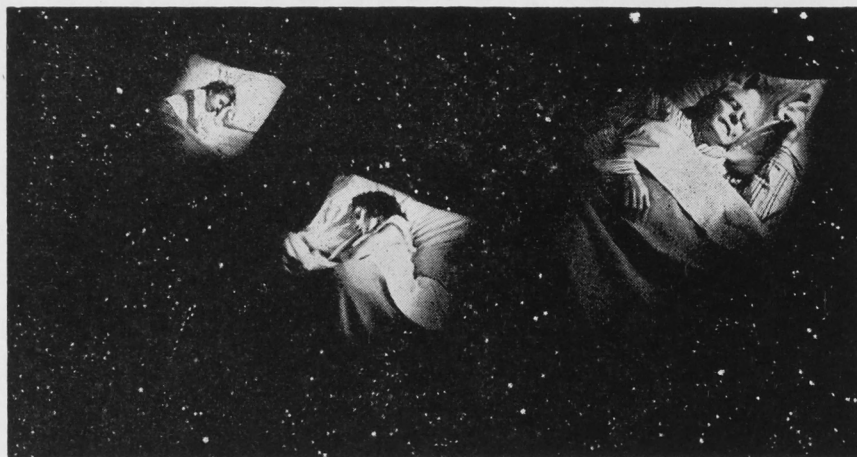
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Children," *Pediatrics*, 40, 761, (1952). Also Andelman, Gerald, Rambar and Kagan, "Effects of Early Feeding of Strained Meat to Prematurely Born Infants," *Pediatrics*, 9, 485, (1952).

Babies had a 40% lower morbidity rate when fed meat than when not fed meat, and had fewer colds. H. M. Jacobs and G. S. George, "Evaluation of Meat in the Infant Diet," *Pediatrics*, 10, 463, (1952).

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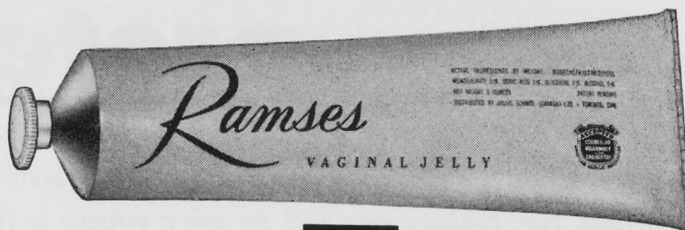
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References.

1- Macht, David, I., Special Pharmacology of Digitoxins. Arch. Int. Pharmacodyn. LXXXI No. 3, P. 345, March 1950. 2- Schwartz, G., A Clinical Investigation of the Digitoxins. American Practitioner and Digest of Treatment, Vol. I, January 1950. 3- U.S. Pharmacopoeia. XIII. 4- Tice, L.F., Amer. Journal of Pharmacy, April 1947, vol. 119.

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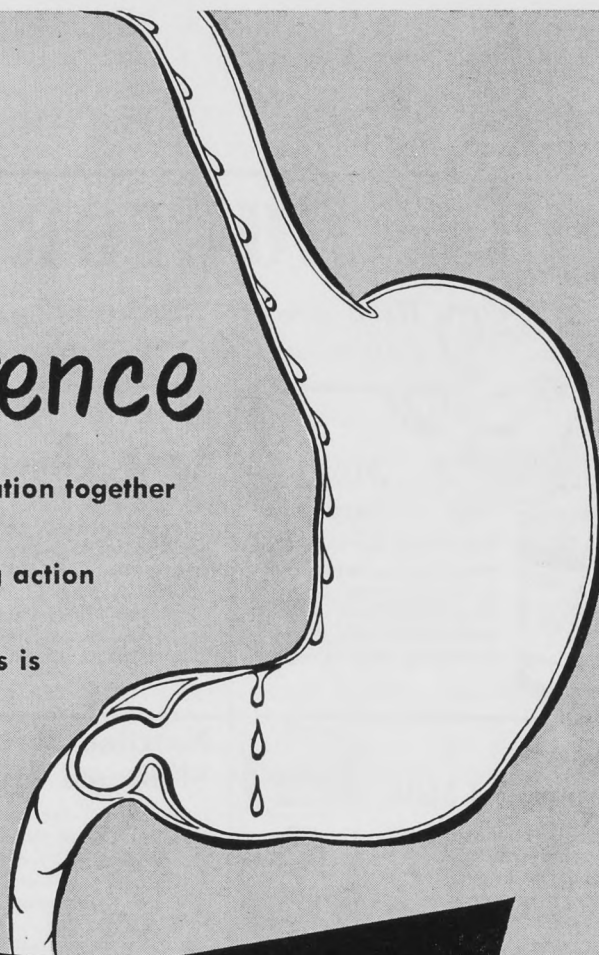
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The Manitoba Medical Review

Vol. 33

AUGUST - SEPTEMBER, 1953

No. 7

Medicine

Immediate and Long Term Management of Chemical Burns of the Oesophagus

C. B. Schoemperlen, M.D., F.A.C.P., F.C.C.P.*

The commonest cause of oesophageal burns with resultant strictures continues to be lye in its various forms; swallowed either accidentally or in suicidal attempts. The old axiom, "Once a lye stricture always a lye stricture," is not true unless the patient will not co-operate or one cannot initially enter and maintain a satisfactory lumen in the oesophagus.

Usually the diagnosis is obvious because of the evident burns of lips, mouth, pharynx; excessive salivation and initial reluctance to swallow because of pain. At times one must rely on the statement of the parents. (X-rays are usually negative at this stage). Oesophagoscopy should be done only if there is doubt. After a few days there may be a latent period of 2 to 6 weeks when swallowing is fairly normal and then symptoms of oesophageal obstruction become evident. At this stage X-rays will confirm the diagnosis, especially if thick barium is swallowed and oesophagoscopy will also demonstrate the site and extent of the lesion.

Commonest sites in order of frequency are (1) The crossing of the left bronchus, (2) The crico-pharyngeus, (3) The cardiac end.

Unfortunately we do not usually see the patient until he has a well established stricture but since Salzer in 1920 advocated early bougienage with soft rubber bougies weighted with mercury, this stage can be prevented in a large number of cases. I prefer to start this bougienage within 72 hours and this is the one point I would particularly like to emphasize to General Practitioners.

Each case requires individualization and the number of dilatations and the intervals between each necessarily varies according to time interval from ingestion to the first treatment and the degree and extent of burning and stenosis.

The following is a useful outline of treatment:

1. Acute Phase

(a) Neutralize—acids with sodium bicarbonate or magnesium oxide—caustic alkalies with vinegar, orange or lemon juice—olive oil.

*Read at The Annual Meeting, Manitoba Medical Association, October, 1952.

(b) If patient is removed from a centre where adequate treatment can be carried out he should probably be given a twisted silk thread to swallow so that it will act as a guide for introducing metal sounds at a later date. Otherwise, if untreated, the oesophagus may become completely occluded.

2. Prophylactic Treatment to Prevent Stricture Formation

Salzer Method—Bougienage with Mercury-filled bougies (Hurst). e.g. daily 2 weeks; 3x week for 2 weeks; 2x week for 2 months; 1x month for 6 months; 2 or 3x year for several years.

3. Management of Chronic Strictures

(a) Blind Bougienage—Hurst O.K.

(b) Peroral oesophagoscopy Bougienage (composition—web; filiform).

(c) Peroral Bougienage with Silk Thread as a guide (Plummer, Sippy-metal).

(d) Retrograde Bougienage (Tucker).

(e) Surgical repair of oesophagus.

4. **Antibiotics**—used routinely in acute phase, and in chronic strictures if infection suspected or evident.

5. **Cortisone and ACTH**. Said to prevent stricture formation.

Anaesthesia

Infants and small children are dilated whenever possible without anaesthetic or under Ether or rectal Pentothal and Ether. Adults are usually dilated under local anaesthetic with either a 2% or ½% solution of Pontocaine. When an anaesthetic is required for adults, Pontocaine is first applied locally and then Pentothal and Curare or one of the allied relaxants is used intravenously.

The following are a few illustrative cases of the problems one encounters and the frequency of treatment employed: Dates of treatments are indicated.

Case 1

Tommy L., 2 years.

May 12, 1950—Swallowed lye accidentally.

May 13—X-ray Negative.

May 15—Dilated 16-20 F. Hg. Bougies. No

Anaesthetic.

May 15, 16, 17, 18, 19, 20, 23, 26, 27, i.e. daily 1st 2 weeks. Then 4 x third week.

June 2, 7, 9, 13, 19, 26. July 10. Total 21 x.

X-ray May 27, 1950-July, 1950—Negative.

December, 1950—X-ray Negative.

This case illustrates an excellent result with early Bougienage, starting on the third day and continued for 2 months, requiring 21 treatments. Two years following the ingestion of lye, he still had no symptoms.

Case 2

Jimmy L., 20 months.

Sept. 16, 1948—Swallowed Lye accidentally.

Oct. 15, 1948—X-ray-narrowing aortic arch, oesoph. dilated above, narrowing cardiac end.

Oct. 19—Oesophagoscopy. Annular stricture at arch. Lumen only 1-2 mm. diameter. Dilated to F. 16 Web Bougies. Peroral Oesophagoscopic bougienage. 2 x a week for 13 weeks. Every 5 days 9 x to March, 4, 1949.

1949—March 11, 18, 26. April 4, 14, 28. May 12, 26 (F. 23). June 16, 30. July 21. August 18 (F. 25). Sept. 15. Oct. 13. (F. 28). Oct. 16, F.B. (Sausage) Nov. 10 (F. 30). Dec. 15.

1950—Jan. 19. March 2 (F. 32). May 13. Aug. 2. Dec. 8.

1951—May 18 (F. 32). Small scar left side lumen. Oct. 3 (F. 34). Total 59 x).

This boy was almost completely stenosed when first seen one month after his accident. Progress was very slow at the beginning and a period of 8 months' treatment elapsed before the interval could be lengthened to 1 month. However, in the third year of treatment, he was dilated only twice. Here, the importance of persistent and regular dilatations is emphasized. It is worthy of note that for each of his 59 treatments, he was given rectal Pentothal and Ether. He developed one of the complications of oesophageal stenosis in that a foreign body was lodged in October, 1949, and had to be removed. Ultimately, all that one could see of the stenosis was a small scar on one side of the oesophageal lumen.

Case 3

Miss B. R., 56 years.

Oct. 5, 1951—Swallowed Lye and Iodine.

Oct. 14—Burns-pharynx, epiglottis, larynx. Dilated 20-36 Hg. Bougies. X-rays Oct. 22 and Nov. 17 Negative.

Oct. 16, 18, 20, 23, 30 (F. 36). Nov. 2.

Nov. 6—F. 38 held at Cardia.

Nov. 9—F. 40 held at mid oesophagus.

Nov. 13—F. 40 held at mid oesophagus.

Nov. 16—Oesophagoscopy—Some narrowing at cricopharyngeus and at left bronchus. Dilated with 10 x 14 scope.

Nov. 20—(F. 40); 27.

Dec. 4, 6, 12, 19, 21, 28.

1952—Jan. 9, 23. Feb. 6, 27. March 26. July 8. (Total 27 x).

This lady also had severe burns of her pharynx, epiglottis and larynx, which healed without laryngeal stenosis but part of her epiglottis sloughed. Although treatment was not started until the ninth day, and in spite of the fact that she did develop some stenosis, she was easily managed with the Hurst bougies and was treated 27 times in one year.

Case 4

Mrs. J. S., 29 years.

May 24, 1952—Swallowed Lye.

May 28—Oesophagoscopy-Hypopharynx and upper 1/3 of oesophagus burned and necrotic (not examined further). X-rays June 6 and 18. Some spasm at left bronchus—no definite stricture.

29 May—22-32F Mercury

30 May—30-39 Mercury

31 May—30-39 Mercury

1 June—30-42 Mercury

2 June—32-39 Mercury

3 June—32-39 Mercury

4 June—32-39 Mercury

5 June—32-39 Mercury

6 June—30-36 Mercury

7 June—30-36 Mercury

9 June—26-34 Mercury

10 June—28-36 Mercury

11 June—26-32 Mercury

12 June—26-36 Mercury

13 June—26-36 Mercury

14 June—26-34 Mercury

15 June—26-32 Mercury

16 June—26-36 Mercury

17 June—Oesophagoscopy—oes. grossly involved—necrotic. Mid oesophagus narrow.

19 June—22-30 Mercury

21 June—24-34 Mercury

23 June—24-32 Mercury

25 June—24-32 Mercury

27 June—23-33 Metal

Patient then went A.W.L. Returned unable to swallow saliva.

- 5 July—18-24 Mercury
 - 7 July—24 Mercury
 - 9 July—29 Metal
 - 11 July—30 Metal
 - 14 July—32 Metal
 - 16 July—34 Metal
 - 18 July 35—Metal
 - 19 July—X-ray long stricture at left bronchus.
 - 21 July—35 Metal
 - 23 July—36 Metal
 - 25 July—36 Metal
 - 28 July—38 Metal
 - 30 July—Oesophagoscopy—stenosed about mid 1/3.
 - 5 August—X-ray—Improved.
 - 8 August—38 Metal
 - 12 August—39 Metal
 - 15 August—40 Metal
 - 22 August—41 Metal
 - 27 August—42 Metal
 - 3 September—42 Metal
 - 10 September—43 Metal
 - 18 September—44 Metal
 - 25 September—45 Metal
- (47 x)

This lady was seven months pregnant and had fairly advanced mitral stenosis. She had very severe burns to her whole oesophagus, mediastinitis and aspiration bronchitis and pneumonitis. In spite of early treatment on the 4th day, her oesophagus closed down and then when she went A.W.L. on the 27th of June, it completely closed off, necessitating subsequent dilatations with the metal sounds because of the inability to pass the mercury bougies. Ultimately, she had a good result after 47 treatments in 4 months. Dr. D. Snidal was primarily responsible for the success.

Case 5

Mrs. S. S., 25 years.

March 25, 1951—Swallowed Nitric Acid.

April 25, 1951—X-ray—extensive involvement from left bronchus distally, including stomach (extra gastric pocket). Oesophagoscopy—palate, pharynx, hypopharynx, larynx cricopharyngeus all involved. Oesophagoscopic bougienage as unable to tolerate thread. Adhesions frequently cut with electro-cautery. (Hypopharynx).

1951—April 25, 27, 30. May 3, 7, 10, 14, 18, 23, 25, 29. June 1, 12, 13 (F.B.), 19, 26. July 4, 16, 27. Aug. 8, 25. Sept. 20 (Difficulty), 26. Oct. 4, 23. Nov. 12. Dec. 1, 20.

1952—Jan. 11. Feb. 7. March 4, 27. April 29. May 27 (F. 40 easily). July 29. Aug. 21 Oct. 3. (Total 38 x).

This lady was almost starved and was very emaciated when seen one month after the onset. At that time she had involvement of her chest, nasopharynx and oropharynx, plus the full length of her esophagus and the upper end of her stomach. Dilatation was difficult and improvement was very slow, but definite.

Case 7

G. H. S. C., 33 years.

14 months age swallowed Lye. Always had to eat slowly and chew food well. Services 5½ years.

April 8, 1947—1st treatment—Oesophagoscopy—Marked stenosis starting at left bronchus. Dilated No. 28 Web. X-ray extensive narrowing from left bronchus distally and at cardia. Some dilatation above stricture.

April 22—Upper stricture dilated to 22 F. and cardia to 20 F.H. rubber. Then metal dilators over thread—occasionally blind bougienage with Web Bougies.

May 2, 6, 9, 13, 16, 20, 23, 27, 30. June 20. July 4, 8, 15, 25, 29. Aug. 22. Sept. 12, 16. Oct. 10, 24. Nov. 18, 21, 28. Dec. 5, 12, 19.

1948—Jan. 6, 20. Feb. 3, 17. March 5, 16, 23. April 6, 20. May 4, 25. June 15. July 13, 16. Aug. 17, 24, 31. Sept. 21. Oct. 22. Nov. 12. Dec. 16.

1949—Jan. 29—Thereafter advised to use Hg Bougies at home once a month. (Total 50 x).

This man had a fascinating history, having ingested his lye almost 32 years before treatment was begun. There was extensive involvement of his esophagus and the stenosis was very firm, so that dilatation was extremely difficult at the beginning and many treatments were required in the first year, but ultimately the result was excellent.

Summary

(1) Oesophageal burns must be treated early and dilatations started within the first 72 hours, if possible.

(2) Although progress may be slow at the beginning, treatments must be carried out regularly and the co-operation of the patient is essential. In this way, most severe and disabling strictures of the oesophagus can be prevented.

(3) If one is successful in obtaining a lumen in the oesophagus, this can almost always be successfully dilated and the patient returned to normal health even though the stenosis may be long-standing, extensive and severe.

(4) Do not be misled by the latent or silent period following the initial burns.

(5) Finally, let us all do our utmost to prevent these unfortunate accidents.

Prints

Figure 1—Hurst Mercury Filled Bougies.

Figure 2—Web oesophageal Bougies.

Figure 3—Jackson Filiform Bougies with Flexible tip.

Figure 4—Sippy Metal Oesophageal Dilators.

Figure 5—Dilatation with the Mercury filled Bougie.

Figure 6—Introducing the Sippy dilator over a previously swallowed silk thread.

Figure 7—(Case 2)—Extensive narrowing from aortic arch distally and also at cardiac end with dilatation of oesophagus above each stricture when first seen. Progressive increase in calibre of lumen; decrease in dilatation and length involved under regular treatment.

Figure 8—(Case 4), June 6—Some spasm at left bronchus but no definite stricture. July 19, while under treatment, she developed a long stricture which was successfully dilated with metal sounds. (Sept. 25).

Figure 9—(Case 7)—Extensive stenosis of 32 years duration. Slowly but successfully dilated with metal sounds.

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2. Gellis, S. S. and Holt, L. E., Jr.: The treatment of lye ingestion by Salzer method. Amn. Otol., Rhin. & Laryng. 51:1086-1088 (Dec.), 1942.
3. Hartman, Journal of Pediatrics, November, 1953, page 634.
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Figure 1

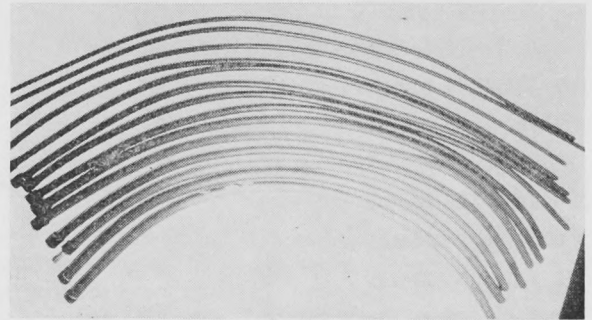


Figure 2

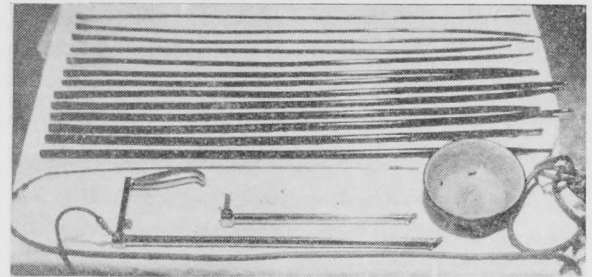


Figure 3

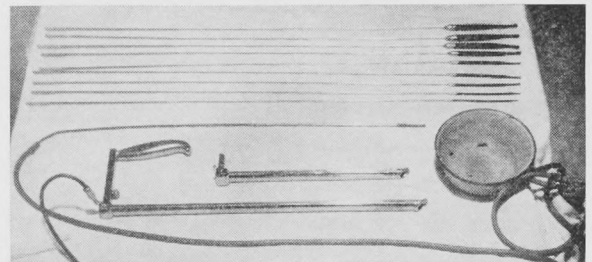


Figure 4

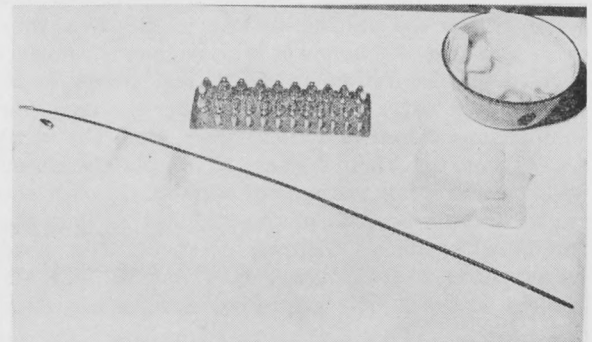
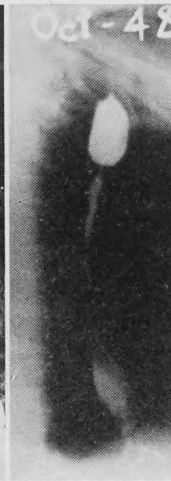




FIG. 5



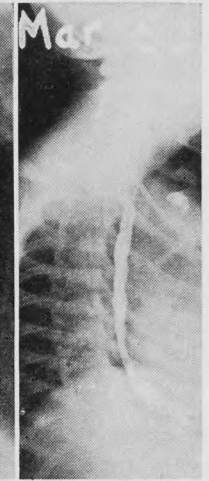
Oct-48



Dec 48



Feb 49



Mar 49

FIG. 7

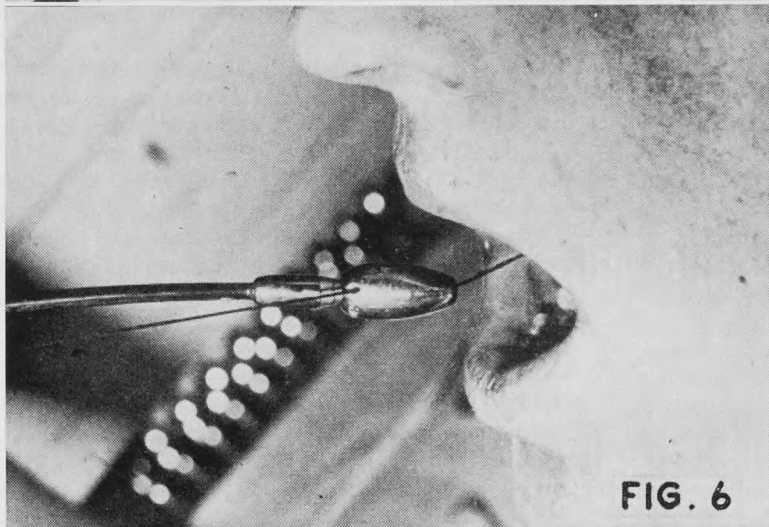


FIG. 6

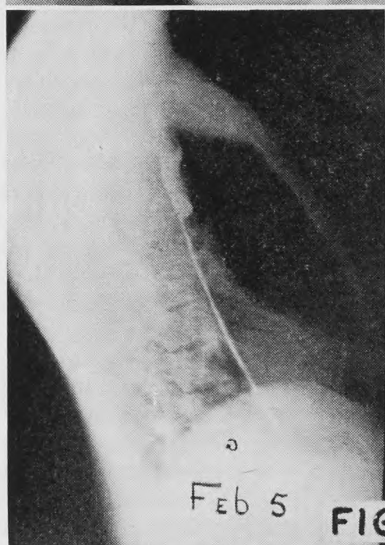


FIG. 8

JUNE 6

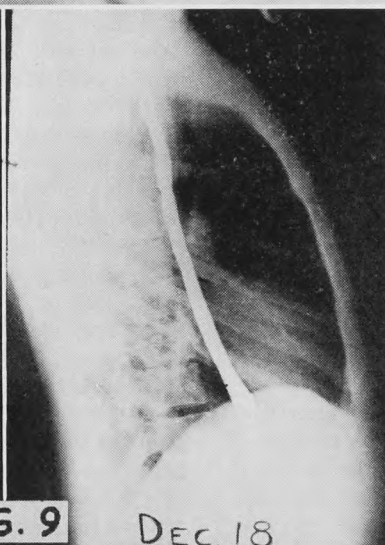


July 19



FEB 5

FIG. 9



DEC. 18

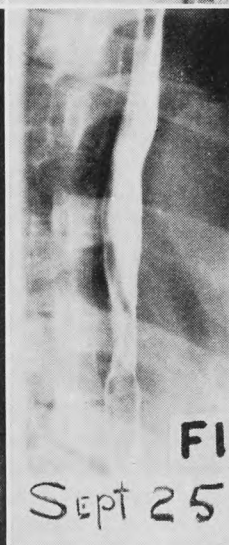


FIG. 8

Sept 25



Aug 5

Heredity and Environment

From "Medicine" by A. E. Clarke-Kennedy

Nevertheless in the present state of knowledge it is impossible to give a practical account of the causation of the natural phenomenon of disease on the basis of the rational classification foreshadowed at the end of the last chapter. Its nature is such, it would appear, that its causes cannot in practice be set out simply in terms of faults in the genetic plan whence the individual is derived, adverse factors in the environment in which he lives, and the use or misuse which he makes of the free will with which he is endowed, as might have been expected at first sight. For this there are several reasons.

In the first place, life as ordinarily understood starts at birth but biological existence begins at conception, when the plan whence the individual is derived is laid and starts to develop, with the result that by the time the child is born it has already been growing for nine months behind the scenes in the internal environment of its mother's body. A defect discovered in it now (or at some later date although present at birth) may have been due equally well either to a fault in the genetic plan, which rendered its proper development impossible, or to some adverse influence on development during intra-uterine existence, which spoilt the execution of what might otherwise have been a perfect plan or, as is more likely, to the interaction of both these factors. True that a defect transmitted from generation to generation is generally regarded as genetic if the same adverse environmental factor capable of producing it and acting in every generation can be excluded with reasonable certainty (the pseudo-inheritance of environment is very easily confused with true heredity); and must be in part genetic, if it can be proved to be transmitted according to Mendelian laws. True also that some congenital conditions seem to be attributed to factors known to be capable of influencing intra-uterine development adversely or to mechanical injury to the child at birth. But in most cases the evidence pointing one way or another is unconvincing and most congenital abnormalities, birth injuries excepted, are probably due to the interaction of genetic and adverse environmental factors.

In the second place, genetic factors probably play a much larger part in the pathogenesis of the "acquired" diseases of later life than was previously supposed. Even individual proneness to commit misjudging may, it now seems, be to some extent genetic; and there is certainly evidence that genetic predisposition determines susceptibility to different types of vitamin deficiency, many chemical poisons and some infections while, after all the necessary allowance has been made for the peculiar dangers of certain predominantly

male and female occupations, many diseases occur more frequently in one sex than in the other. This tendency must be genetic. In fact, clinical experience teaches that most clinical conditions are due to the coincidence of sex, a particular genetic weakness and the action of adverse environmental factors with the result that the view held as to the causation of many diseases often depends to a large extent on the standpoint of the particular observer. For instance, the practicing doctor seeing a number of cases of scurvy or tuberculosis in a particular family among people living on a poor diet in his district is likely to suspect individual genetic weakness rather than some dietetic factor common to all his "registered" patients. On the other hand a Public Health Officer discovering a high statistical incidence of one of these diseases in a community for which he is responsible is likely to think in terms of adverse environmental factors rather than of individual predisposition in members of certain families which he has never actually seen. For this reason in the eighteenth century, the age of clinical observation, most diseases were attributed largely to inherited diathesis but in the nineteenth, when the standard of living declined and the public health services were first started, they were attributed mainly to the influence of adverse factors in environment. In the twentieth century it can be seen that there was truth in both those points of view, and although it is now realized that it is impossible to separate heredity and environment in the pathogenesis of the individual case, we can assess their relative importance in the pathogenesis of a disease in general much more accurately.

Thirdly there are a number of conditions which are met with again and again in the practice of clinical medicine of which the pathogenesis is quite obscure or at least still remains to a large extent uncertain. New growth and the degenerative processes of advancing age are good examples. New growth may be due to adverse factors in environment, as some modern work would seem to show; or to some genetic predisposition which comes into action at a certain age, as some studies in heredity suggest; or, as on the whole would seem more probable, to some combination of both these causes. Similarly degenerative changes in the tissues may be due to some fault in the genetic plan, as the frequent death of identical twins from arteriosclerotic causes at about the same age and the histories of many short-lived families would seem to show; or to the summation of the stresses and strains to which every individual is to some extent exposed, as the Registrar-General's returns of the relation of age of death to individual occupation suggest; or again, as on the whole would seem more probable, to some combination of both these causes. For as yet there are no certain answers

to these questions and in the meanwhile new growth and the degenerative changes in the arteries and tissues generally which are associated with advancing age, whatever may prove to be their ultimate cause (if indeed it is ever discovered), must be reckoned among the causes of disease and included in the major risks in life to which every individual ageing human body is exposed.

Lastly consciousness complicates the problem of the causation of disease. For, on the one hand, the development of the brain, which depends on the same factors as the development of any part of the body, conditions the way in which the mind develops under the stimulus of experience. Further transient or permanent alterations in its physical state profoundly influence the reactions of the mind to experience. On the other hand the mind thus developed, as has been seen already, can influence the body in two ways. Emotional states exert a profound influence on visceral function through the autonomic nervous system; volition on behaviour and conduct through the skeleto-motor system. Thus mind and body are not distinct entities (although man inevitably thinks of them as such) and cannot really be divorced from each other. Rather they must be one, different aspect of the same underlying reality (the nature of which the human mind cannot conceive), body and mind developing together from birth and being maintained together throughout life each (for man cannot help thinking of them separately) for the whole of this time acting and reacting back upon the other. Such, as has been seen, is the psychosomatic nature of mankind (see page 38). In consequence, as will become clearer later, it is often difficult, and sometimes quite impossible, to distinguish the relative importance of physical and psychological factors in the pathogenesis of many clinical conditions.

The risks in human life which are the causes of disease cannot therefore in the present state of medical knowledge be classified neatly on any strictly rational basis and any account of them must remain inevitably to a large extent empirical. One of several different methods of presentation could therefore have been adopted, but the account which follows seems to be both the most rational and the most practical of all the available alternatives. For it describes these risks as the layman tends to view them, as the doctor is likely to meet them, and in the order in which the individual is liable to succumb to them as his "life" progresses from his conception to his birth and then from his cradle to his grave. It starts with the risks to which the future individual may be exposed at his conception and during his intra-uterine existence followed by an account of congenital conditions. It continues with a description of the adverse physical factors to which his body runs the risk

of becoming exposed from his birth onwards: lack of food, water, minerals or vitamins; chemical poisoning; physical injury; and infection to which he may be predisposed to succumb on account of the way in which he has developed under the stimulus of heredity and environment. Then follows an account of the adverse factors to which his mind is exposed and to which he may be predisposed to succumb on account of the way in which the development of his brain has conditioned the development of his mind. It finishes with an account of new growth and old age, accepted risks in every human life which cannot yet be satisfactorily explained.

The above is taken from Clarke-Kennedy's "Medicine" of which a second edition is now being issued. Only Volume 1 is yet available and it is entitled "The Patient and His Disease."

This is not at all a stereotyped text-book. Classification by systems and the usual sequence of definition, etiology and so on are absent. In the author's words the book "is intended to correlate the facts, and, by cutting across the conventional boundaries which separate one branch of medicine from another, emphasize the general principles underlying medicine as a whole. It is intended to inculcate an attitude of mind."

Medicine is an Art as well as Science. Indeed it is more Art than Science and has been so through all time. Clarke-Kennedy feels that students and practitioners are taught perhaps enough about the science of their art but certainly too little about the art of their science and his book is a corrective. In times past when doctors formulated their own prescriptions a corrective was frequently added to neutralize some undesirable property and to make the remedy palatable. The word "corrective" is therefore well applied in this instance.

The 410 pages of Volume 1 are divided into six chapters and an index. The Chapter Headings are: Body and Mind; Symptoms; Symptoms and Signs; Heredity and Environment; Reactions of Body and Mind; The Nature of Disease. Each chapter is subdivided into sections and these are divided again into topics.

The selection printed above will give an idea of the author's style. The book is most readable and it is "broadening" also because it stirs thought and begets that attitude of mind which makes practice more meaningful. No one could possibly fail to enjoy reading it or find the reading without profit.

Medicine, by A. E. Clarke-Kennedy, M.D., F.R.C.P., Fellow of Corpus Christi College, Cambridge; Physician to the London Hospital and Dean of the Medical School. Volume 1, The Patient and His Disease. Second Edition, the MacMillan Company of Canada. Price \$4.75.

Cardiology

Cardiac Pain

B. H. Lyons, M.D., F.R.C.P. (C)

The patient who comes to the physician's office complaining of chest pain is generally anxious about his heart. As a rule the onset of coronary disease is striking—even dramatic—and leaves little doubt as to the diagnosis. A common story related by the patient is that he had been perfectly well, but now finds that when hurrying to catch his bus after a good breakfast, he is seized by an oppressive or constricting pain beneath his breastbone. The distress compels him to slow up, and when he stops it is quickly relieved. Such a story can mean hardly anything but angina pectoris.

At times however the history is not so classical. The patient may be a poor observer and unable to give a clear account of his symptoms; or the pain may be atypical with respect to location, quality, duration or relationship to effort. It may thus suggest to us other diagnoses, such as disorders of the spine and chest wall, or of esophagus and stomach. Our difficulties are often increased by the frequent co-existence of coronary disease with one of these conditions. In fact it appears well established that coronary disease, through referred pain or other noxious reflexes, may give rise to pathologic changes about the shoulder joint or chest wall. The discomfort from these lesions then has to be differentiated from the cardiac pain *per se*.

Time does not permit detailed discussion, so I will emphasize a few diagnostic points only.

Anginal pain may at times be localized or maximal in unusual sites. I have seen cases where pain was limited to the left forearm, in the left axilla, under the clavicle or above the scapula. I do not recall ever seeing it localized to the apical area (**below** the nipple). This is a fortunate circumstance, since it at once rules out of consideration the large number of nervous people who come complaining of pain in this region, where they imagine their hearts to be.

The pain is always diffuse, and the patient will place his hand on his chest to indicate the area of distress. If he points to the site of discomfort with a finger, the trouble is probably in the chest wall.

The words used by the patient to describe the character of his pain often give a clue to the diagnosis. Angina means strangling, and describes the vice-like constriction or pressure commonly experienced. Not infrequently however the description will be of heartburn, or a feeling of gas

crowding under the lower sternum which must be rifted. These latter symptoms may bring the patient to the office with a complaint of indigestion. If the pain is described as sharp or stabbing we should look for the trouble elsewhere.

Severity of pain is not a reliable guide as to its nature or gravity. Anginal pain may be excruciatingly painful, but it may also be so mild that the patient does not even complain of it. I have more than once elicited a history of angina during routine history taking, when the patients presented with some other complaint; and they wondered why I paid so much attention to the symptom.

Patients always overestimate the duration of pain. If they are asked to time it, nearly always it will be found to last less than three minutes. Angina decubitus, however, tends to take longer—up to 10 or 15 minutes. Beyond that we should consider coronary insufficiency or infarction.

Associated with no other type of pain is "angor animi"—the fear or consciousness of impending death. This fearsome and peculiar sensation is however experienced by a minority of patients only. It is not dependent on severity of pain, nor altogether on fear, but appears to be in the nature of a protective reflex. The late John Ryle, who himself had angina and had experienced *angor animi* repeatedly, speculated as follows; "The sense of dying might be described as the aura of a nervous storm having its vortex in the medullary centres upon which the act of living depends," and "There is a motor as well as a sensory part to this strange reflex. It includes the instant immobility which is so striking a feature in angina."

Coronary pain comes on only as the result of some factor which causes a disproportion between cardiac work and oxygen supply. The usual cause of course is physical effort. The nature of the activity is important in diagnosis. Thus if the patient tells us that his pain developed while pushing a stalled car, or (as I see by the advertisements), a lawn mower—his coronaries may have been inadequate. On the other hand the distress might equally have been caused by acute strain of skeletal origin. Any effort therefore, which involves the use of arms or thorax should not be accepted without reserve as indicating heart pain.

Even should the distress come on in the classical manner—while walking or hurrying—we must remember to inquire if shortness of breath was present. In the first place increased respiratory effort may give rise to chest wall pain. Secondly if the patient has chronic pulmonary disease—for example emphysema—he may have attacks of pain resembling angina, the mechanism of which is not well understood. (It has been suggested that

the mechanism of pain in these cases is stretching of the pulmonary artery due to pulmonary hypertension.) Unless the anginal patient has some other condition which may cause dyspnea, effort will as a rule give rise to pain before shortness of breath is experienced. It is well to remember what Heberden wrote about angina 180 years ago: "In all other respects, the patients are, at the beginning of this disorder, perfectly well, and in particular have no shortness of breath, from which it (angina), is totally different." It is true that on being questioned the patient will often state that he had difficulty in breathing; but if he is then asked whether he was **panting** it will usually be elicited that his sensation of dyspnea was due to immobility of his respiratory muscles during the attack.

When anginal pain occurs apart from physical effort, some other cause which may increase cardiac work or diminish its blood supply should be evident—for example emotional upsets, tachycardias, or overloaded stomach. It is apparent that diagnostic difficulties will arise unless there is also a history of pain on effort.

Pain which occurs at rest in bed, or angina decubitus, is usually a late symptom and therefore does not present any problems. However rest pain may at times be the earliest complaint in which case we fear actual or impending infarction. Occasionally angina as such may begin at rest before it has occurred on effort in patients who are very sedentary. It is presumed in these cases that the work of the heart has been increased by the larger venous return in the recumbent position. Other causes however may be evident—such as cold bed sheets, nightmares, or certain physical or emotional activities which are commonly indulged in the decubitus or recumbent position.

Nitroglycerine usually gives prompt relief in anginal pain. However it is not completely diagnostic since other types of pain are at times also relieved. Nor does nitroglycerine relieve the prolonged pain of coronary insufficiency.

When we have completed our history we should in the large majority of cases be able to make a presumptive diagnosis. We then turn to our further examinations. Hypertension, cardiac enlargement, or electrocardiographic abnormalities by revealing the presence of heart disease will support a diagnosis of angina.

A negative physical examination helps us to eliminate the diagnosis of angina in female patients since there is a 90% incidence of hypertension in non diabetic females with angina who have not had an infarct. But the large majority of our coronary patients are men, and the absence of positive findings in their case means nothing. One-third to one-half of them will be completely normal by the usual objective methods

including the resting electrocardiogram. If we are unsure of our clinical diagnosis and begin investigating, we are quite likely to discover an arthritis of the spine, a hiatus hernia or perhaps gallstones. Such findings may only serve to mislead us, since we may tend to accept what we can demonstrate objectively, rather than rely on what the patient tells us.

Some further method of examination to provide objective evidence of coronary disease was needed to assist us, especially in cases where the symptoms deviated from the classical. Such a procedure, now frequently used, is the exercise or step test. The test is based on the fact, known for many years, that during an attack of angina changes could be recorded with the electrocardiogram which were diagnostic. Dr. Arthur Master of New York standardized and popularized a method for office use. He demonstrated that a positive result was not necessarily dependent on the occurrence of pain with the exercise. His technique consisted of walking a patient up and down a set of two steps—hence the name "Master Step Test" (Fig. 1). The number of trips over the steps was regulated according to tables based on sex, age and weight

Figure 1



(Fig. 2-3). Thus (referring to the tables), a male patient aged 50 and weighing 150 pounds would

Figure 2

TABLE I
Standard Number of Ascents† for Males*

Weight (lb.)	Age in Years													
	5-9	10-14	15-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	
40-49	35	36												
50-59	33	35	32											
60-69	31	33	31											
70-79	28	32	30											
80-89	26	30	29	29	29	28	27	27	26	25	25	24	23	
90-99	24	29	28	28	28	27	27	26	25	24	23	22	22	
100-109	22	27	27	28	28	27	26	25	25	24	23	22	22	
110-119	20	26	26	27	27	26	25	25	24	23	23	22	21	
120-129	18	24	25	26	27	26	25	24	23	23	22	21	20	
130-139	16	23	24	25	26	25	24	23	23	22	21	20	20	
140-149		21	23	24	25	24	24	23	22	21	20	20	19	
150-159		20	22	24	25	24	23	22	21	20	20	19	18	
160-169		18	21	23	24	23	22	22	21	20	19	18	18	
170-179			20	22	23	23	22	21	20	19	18	18	17	
180-189			19	21	23	22	21	20	19	18	17	16	15	
190-199			18	20	22	21	21	20	19	18	17	16	15	
200-209				19	21	21	20	19	18	17	16	16	15	
210-219				18	21	20	19	18	17	17	16	15	14	
220-229				17	20	20	19	18	17	16	15	14	13	

* Taken from Am. Heart J. 10: 497, 1935.

† An ascent is one complete trip over the steps in one direction.

Figure 3

TABLE II
Standard Number of Ascents† for Females*

Weight (lb.)	Age in Years													
	5-9	10-14	15-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	
40-49	35	35	33											
50-59	33	33	32											
60-69	31	32	30											
70-79	28	30	29											
80-89	26	28	28	28	28	27	26	24	23	22	21	21	20	
90-99	24	27	26	27	26	25	24	23	22	21	20	20	19	
100-109	22	25	25	26	26	25	24	23	22	21	20	19	18	
110-119	20	23	23	25	25	24	23	22	21	20	19	18	18	
120-129	18	22	22	24	24	23	22	21	20	19	19	18	17	
130-139	16	20	20	23	23	22	21	20	19	19	18	17	16	
140-149		18	19	22	22	21	20	19	19	18	17	16	16	
150-159		17	17	21	20	20	19	18	17	16	15	14	13	
160-169		15	16	20	19	19	18	18	17	16	16	15	15	
170-179		13	14	19	18	18	17	17	16	16	15	14	13	
180-189			13	18	17	17	17	16	16	15	14	14	13	
190-199			12	17	16	16	16	15	15	14	13	13	12	
200-209				16	15	15	15	14	14	13	13	12	11	
210-219				15	14	14	14	13	13	13	12	11	11	
220-229				14	13	13	13	13	12	12	11	11	10	

* Taken from Am. Heart J. 10: 497, 1935.

† An ascent is one complete trip over the steps in one direction.

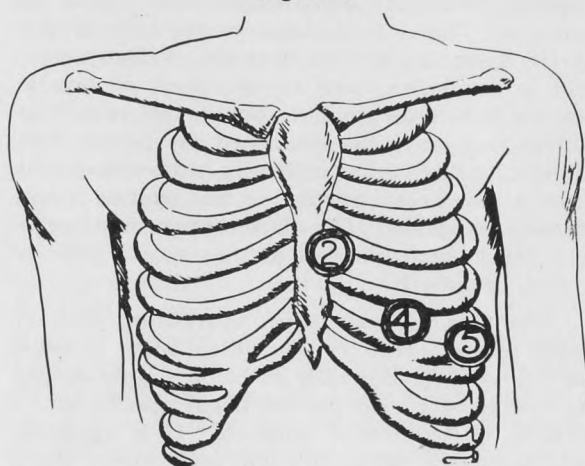
make 20 one way trips in 90 seconds. If the test was negative, the exercise would usually be repeated as the "Double Step Test." In the case illustrated that would mean 40 trips in 3 minutes.

Most authorities have criticized Masters' standardization of the test, arguing that every patient is an individual problem. The degree of coronary narrowing, physical fitness and emotional reaction will all influence the amount of exercise needed for a positive result. I will not go into the details of different methods but will describe the procedure I have adopted.

A control electrocardiogram is first taken, recording the limb leads V2 (on the right), and V4-5 (on the left). The chest electrodes are circled with a ballpoint pen for accurate placement (Fig. 4). The tracing is then read before proceeding. This is an absolute "must" in order to be certain that no cardiac damage has ensued since

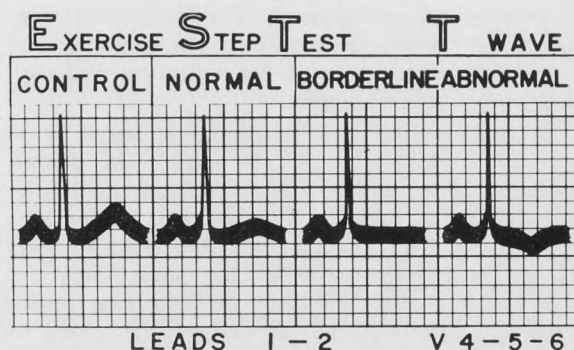
the last previous examination, which might make the test hazardous. The patient then walks over the steps at the rate recommended by Master, but no fixed number of trips is taken. Each case varies depending on the ease with which pain has

Figure 4



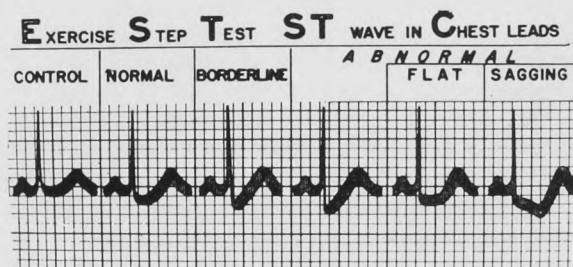
been produced in the past and the patient's reaction during the test. The exercise is usually continued until there is some shortness of breath or fatigue, but is terminated at any time that pain develops. A series of tracings is now taken beginning immediately after the exercise and repeating several times in the next 10 minutes. It is essential to take a series of tracings since the diagnostic changes may show up at various intervals. The most marked changes usually occur about 4-5 minutes after. The tracing immediately after exercise may also be confusing because of changes due to tachycardia. The film is developed and if positive changes are present and persistent, the patient is not allowed up until a repeat cardiogram is normal. Criteria for interpretation vary with different authors, depending partly on the way the exercise is carried out. The rules which I have adopted, with the method described, are as follows: Development of any block or arrhythmia is abnormal. T wave changes are observed in leads 1-2 and V 4-5 (Fig. 5). A change in the amplitude

Figure 5



of the T wave if still upright is ignored. If the T wave is flat it is considered borderline, although some would regard it as pathological. An inverted T. wave is abnormal. ST changes are most readily observed in the chest leads (Fig. 6), where they

Figure 6

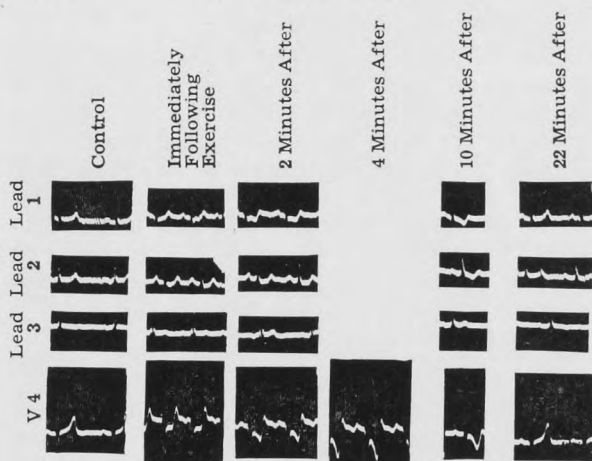


are usually about twice the amplitude of the limb leads. A depression of 2 millimeters in the chest leads is considered diagnostic, while $1\frac{1}{2}$ millimeters would be borderline. A depressed upwardly sloping ST segment is often seen in tachycardia—consequently in borderline tracings we are influenced by the cardiac rate in our interpretation. More significant is the contour of the ST segment. A flat, or better still a sagging line has much significance. Paul Wood states that in such cases a depression of 1 millimeter is adequate for diagnosis.

Figure 7 is an example of a markedly positive test. Observing V4 it will be seen that the ST

Figure 7

Mr. H. D. Master Step Test



segment in the control tracing is isoelectric. Following exercise it becomes depressed and then sagging, reaching its maximum 4 minutes later. At 22 minutes the tracing is normal again.

This case presented unusual problems for 20 years and the diagnosis could not be established

until a step test was done.

The patient was a man aged 70, who 20 years before began having acute attacks of pain described as "wringing," above the left scapula. When severe the pain would radiate anteriorly to the second intercostal space and occasionally to the left arm. The attacks came on with effort, especially while walking, and also with emotional disturbances, and were relieved by nitroglycerin. From the very beginning he also had pain while at rest in bed. Following each attack aching pain persisted for hours and finally was present continuously. Partial relief could be obtained by extending his neck and by hot applications. Examination disclosed tenderness and hyperesthesia over the second left dorsal dermatome. X-rays of the cervical spine revealed marked osteoarthritis. The electrocardiogram remained normal during the entire 20-year period of observation. Over the years he was seen by many physicians, neurologists and orthopedists, and opinions were divided as to the diagnosis.

A step test was carried out, during which the patient developed his usual acute pain, and the subsequent electrocardiographic tracings revealed the striking changes illustrated. At a later date an opportunity presented itself to record a tracing during an attack which came on spontaneously at rest, with similar results.

The diagnosis of angina was thus substantiated. The continuous pain, hyperesthesia and tenderness was felt to represent a local lesion secondary to reflex influences from his heart, or to a pre-existing pathological area to which the anginal pain was referred (locus minoris resistance?).

One year later the patient suffered a prolonged attack of pain, of the same nature and in the same location as before, but this time it was not relieved by nitroglycerin and resulted in an extensive anterior myocardial infarct.

Obviously such a test must be used with caution since it involves a potential hazard. However if proper precautions are taken the dangers are very remote. Patients who have definitely abnormal electrocardiograms at rest, or other gross evidence of cardiac disease, should not be submitted to the test. As previously stated a control cardiogram should always be taken and read before proceeding. If the history suggests an impending occlusion it is of course not done. The procedure must never be relegated to a technician alone. The physician who has studied the patient must be present and accept responsibility for the performance of the test.

Probably 80% of patients with angina who have a normal resting electrocardiogram will show a positive result—in other words an overall rate of 90% diagnosis by the electrocardiogram. It must be remembered that we are diagnosing coronary

inadequacy and not angina pectoris, which is a diagnosis requiring the history—in the same way that an X-ray showing gall stones does not diagnose biliary colic, although it strongly supports a clinical diagnosis.

However the test does give clinical as well as laboratory information, which is another reason why the physician should be present. It presents

an opportunity of judging the patient's exercise tolerance. Should he develop pain, our observation of his reactions, and what he tells us at the time, will give us valuable information. When a patient during the exercise develops chest pain plus positive electrocardiographic changes, the diagnosis of the clinical syndrome of angina pectoris can be made with assurance.

Anaesthesiology

Abstract

Cardiac Resuscitation: E. S. Palomera, S.G. & O. International Abstracts of Surgery, 95, October, 1952.

More and more are we coming to realize that "cardiac stoppage" is not necessarily synonymous with "elemental death," that is, with irreversible changes in the cells of the vital centres.

This excellent summary reviews the literature under the headings of 1. Incidence, 2. Etiology, 3. Pathogenesis, 4. Diagnosis, 5. Prophylaxis and 6. Treatment of cardiac stoppage.

Everyone concerned with the operating room, be he surgeon, anaesthetist, surgical resident or interne, must be made aware of the possibilities for human salvage when early and adequate cardiac resuscitation is instituted. A premeditated plan of action, which may be copied from or adapted from the above article should be at the finger tips of all personnel concerned.—80 references.

M. Minuck, M.D.

The following outline is a suggested plan of action which might be committed to memory for use when its need arises.

Constant surveillance of a patient under anaesthesia will enable the observer to make an immediate diagnosis of cardiac stoppage.

Step I—When (carotid) pulse and blood pressure disappear and respirations cease cardiac stoppage has occurred. The patient is intubated, placed in 5 degrees of Trendelenburg position, and artificial respiration with pure oxygen commenced immediately. The table should be levelled after about 10 minutes.

Step II—Open into the chest, without regard for asepsis.

(a) Through the 4th, 5th or 6th left costal interspace.

(b) Or through the diaphragm, if the upper abdomen is already open.

Step III—Feel the heart and compress the ventricles. Diagnosis of the type of stoppage can

be made only by direct vision or palpation of the heart.

(a) Quiet, dilated ventricles, "wet blanket"—cardiac standstill.

(b) Wiggly, "bag of live worms"—ventricular fibrillation.

(c) If crepitations are felt in the right auricle or ventricle—air embolus has occurred.

Step IV—If there is no immediate response, open the pericardial sac and compress the heart rapidly at the rate of 60 to 80 beats per minute.

Step V—Without interrupting the compressions one may now inject auxiliary drugs directly into the ventricles: preferably into the left ventricle as from the latter the drugs have a more direct route to the coronary arteries.

(a) Cardiac standstill—

(1) Adrenalin 1:1000 $\frac{1}{2}$ -1 cc. diluted to 10 ccs. with 1% procaine.

(2) Calcium chloride 5% 2-5 ccs.

(b) Ventricular fibrillation—

(1) Potassium chloride 0.5% 2-5 ccs.

(2) Procaine 1% 4-10 ccs.

(3) Electrical defibrillation.

Any of these methods of defibrillation might, if successful, place the patient in the category of cardiac standstill and treatment for the latter, as given for (a) above must then be instituted.

Step VI—Rapid replacement of any blood loss.

To aid in cardiac resuscitation one might set up an emergency tray that would be used exclusively for this type of emergency. This should be kept in an easily-available and well-known location and would contain the following articles.

1. An electrical defibrillator.

2. A supply of at least 6 syringes of 10 ccs. capacity and an equal number of long fine needles.

3. A supply of ampoules containing:

(a) Potassium Chloride, 0.5%

(b) Calcium Chloride, 5.0%

(c) Adrenaline, 1:1000.

(d) Procaine Hydrochloride, 1%.

M. Minuck, M.D.

Surgery

Surgical Treatment of Carcinoma of the Laryngo-Pharynx

Harvey Lister, M.B.

This preliminary report of the operation of lateral pharyngotomy in a case of carcinoma of the pyriform fossa is made—not because of any originality in the method of approach but because of the early diagnosis, enabling the operator to make an adequate excision and a primary wound closure.

Surgical treatment of carcinoma of the larynx whether intrinsic or extrinsic—necessitating either laryngofissure or laryngectomy is a widely practised and long accepted procedure. In cases where the lesion involves primarily the pharynx, surgery has been much less popular—because the wide extent of the tumor and the presence of cervical glandular metastases usually prohibits any conservative excision.

H. B. Orton, writing in "Jackson and Jackson," states: "Growths arising in the pyriform sinus which in the early stages are symptomless until the lateral wall of the larynx and thyroid cartilage are involved, becoming almost inoperable except by extensive operation." In these cases it has usually been necessary to perform such heroic measures as wide excision of the pharynx, complete radical neck dissection and subsequent plastic reconstruction of the pharynx by a skin flap. Even then the results are very discouraging. It is easy to understand why these cases have been passed on to the radiotherapy department to gain a quick response and equally quick recurrence according to the histological features of the tumor.

Mrs. M. F., age 45, was referred to me by a medical colleague on the 18th of March, 1953, with a complaint of "something sticks in my throat when I swallow." Her sensation was localized accurately to the posterior border of the right thyroid lamina. Two months earlier she had consulted a competent laryngologist with the same complaint, then of only three months' duration and had been reassured of the absence of any lesion. The symptom persisted and at the next examination an excrescence of abnormal tissue, no larger than a half pea could be seen on the apex and lateral aspect of the right arytenoid cartilage. At subsequent direct laryngoscopy the mass was seen to have a greater total size and extended down into the depths of the pyriform fossa, without having any further attachment, as demonstrated by lifting it up with the biopsy forceps. Pathological report was "infiltrating epidermoid carcinoma grade 2."

On the 22nd of March, 1953, operation was performed under local and pentothal drip anaesthesia. A preliminary tracheotomy was done. An incision was made along the anterior border of the sternomastoid muscle but in a slightly more vertical plane and extending from hyoid to cricoid level. The strap muscles and the attachment of the inferior constrictor were divided, allowing the thyroid cartilage to be drawn towards the mid line. By subperichondrial dissection the mucosa of the pharynx was separated from the surface of the thyroid lamina, without amputating any portion of cartilage as is commonly described. The mucosal lining of the pharynx was then opened and a flat cauliflower-like mass, roughly circular in shape, 1.2 x 0.9 cms. in diameter and 0.5 cms. in thickness, was exposed on the lateral aspect of the arytenoid. This was excised together with a surrounding area of 1 cm. of normal mucosa. A bite, taken from the underlying submucosa and examined microscopically, failed to reveal any evidence of neoplastic invasion.

The mucous membrane was approximated without tension and the wound closed after inserting one small rubber drain. Tube feeding was carried out for eleven post-operative days. Convalescence was uneventful. The drain was removed on the fourth and the tracheotomy tube on the sixth day. The patient has been examined by indirect laryngoscopy and palpated for any cervical metastases each two weeks and shows no evidence of recurrence. She can swallow all foods and of course the voice is normal.

This case is not reported as a cure at such an early date, but to demonstrate the possibility that something can be done in cases of carcinoma of the laryngo-pharynx without the operative result being crippling or deforming and that an early diagnosis is the principal feature in determining subsequent prognosis. I feel that with the increased "cancer consciousness" of the public and with improved methods of examination we can hope that an increasing number of sufferers may be seen at an earlier stage of the disease than in previous years. It is in this spirit of hope that this communication is sent. May it be accepted in the same way.

H. B. Orton, Lateral Transthyroid Pharyngotomy. *Arch. Oto. Larng.* 12: 320, 1930.

H. B. Orton, Lateral Transthyroid Pharyngotomy. *Ann. Otol. Rhinol. and Laryngol.* 51: 774, 1942.

Trotter W. Purvis, Operation in the Surgery of Malignant Diseases of the Pharynx. *British M.J.*, 1: 269, 1926.

Harvey Lister, M.B.

Association Page

Reported by M. T. Macfarland, M.D.

Outline of Legislation

Seventh Session, Twenty-third Legislature, Which Was Opened on February 24th, and Prorogued on April 18th, 1953

Bill No. 2—An Act respecting the Welfare of Children.

Bill No. 4—An Act respecting the Manitoba Association of Registered Nurses.

Bill No. 6—An Act to amend the Health and Public Welfare Act. The Act provides for the union of the two departments under the one minister. The amendment provides for the appointment of separate deputy ministers of health and public welfare respectively.

Bill No. 7—An Act to amend the Blind Persons' Allowances Act.

Bill No. 8—An act to amend the Old Age Assistance Act.

Bill No. 11—An Act to amend the Marriage Act.

Bill No. 22—An Act to amend the Medical Service Act. The amended Section provides that 2/3 of the members of the Board of Trustees shall be named by the Manitoba Medical Association.

Bill No. 24—An Act to provide for the training, Examination, Licensing, of Practical Nurses.

Bill No. 26—An Act to amend the Health Services Act. The amendment makes a change in the cost of laboratory and X-ray units. Under the amendment the government will pay two-thirds of the costs and the municipalities and areas in unorganized territory will pay one-third.

Bill No. 30—An Act to amend or repeal Certain Provisions of the Statute Law and to validate an Order-in-Council. Definition of "duly qualified medical practitioner" is added to the Interpretation Act since the expression is used in many places in the Statutes.

Bill No. 31—An Act to amend the Tuberculosis Control Act.

Bill No. 33—An Act to amend the Social Assistance Act.

Bill No. 40—An Act respecting the Department of Municipal Affairs. Section 12 provides for a levy as a contribution towards the cost of operating and maintaining nursing stations and outpost hospitals.

Bill No. 43—This Act provides for the expenditure of additional sums of money for the fiscal year ended March 31st, 1953.

Bill No. 53—An Act to incorporate the Ophthalmic Dispensers of Manitoba.

Bill No. 63—An Act to amend the Medical Act.

Bill No. 71—An Act to amend the Dental Association Act.

ciation Act.

Bill No. 72—Estimates for the fiscal year ending 31st of March, 1954.

VII—Health and Public Welfare

1. Executive Division	\$ 246,177.00
2. Health Division	5,937,457.00
3. Welfare Division	3,953,816.00
4. Chargeable to Capital Division	450,000.00
	<hr/>
	\$10,587,450.00

XI—Public Works

21. Operation and Maintenance, Selkirk Hospital for Mental Diseases	\$182,785.00
22. Operation and Maintenance, Brandon Hospital for Mental Diseases	185,435.00
25. Operation and Maintenance, Manitoba School for Mentally Defective Persons, Portage la Prairie	131,905.00

Bill No. 76—An Act respecting the Rural Municipality of Harrison. Authority to pay medical retainer for the Sandy Lake municipal doctor area.

Bill No. 84—An Act to repeal the Basic Sciences Act.

Bill No. 86—An Act to amend the Workmen's Compensation Act. Amendments deal with claim for strangulated herniae. Vocational training facilities may be provided, and treatment may now be given by a Chiropractor or Osteopath without request of the injured workmen to the Board. Maximum limit of compensation for disability is raised.

Canadian Otolaryngological Society

Slate of Officers for 1953-54

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Dr. Robert Black, Winnipeg, Man.

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Next meeting will be held at Harrison Hot Springs, B.C., in June, 1954.

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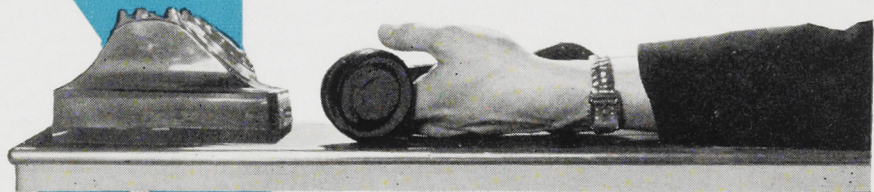
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WALKERVILLE, ONTARIO

Fugitive Pieces

J. C. Hossack, M.D., C.M. (Man.), Editor

More About Mephibosheth and Vulcan

Before I go on to more important affairs I have a little matter to straighten up and I shall do so now. It arises from a communication I have just received and which I print here:

May 13, 1953.

Dr. J. C. Hossack,
401 Medical Arts Bldg.,
Winnipeg, Manitoba.
Dear Doctor Hossack:

In the last issue of the Review under the heading "Fugitive Pieces" you made an excursion into mythical diagnosis in an effort to show that neither Mephibosheth or Vulcan had poliomyelitis as suggested in my recent article in the Students' Journal.

Of course Mephibosheth had poliomyelitis! William Osler made that diagnosis in 1892 and I confirmed it in 1952. The account in the second book of Samuel (4:4) says:

"And Jonathan, Saul's Son, had a son that was lame of his feet. He was five years old when the tidings came of Saul and Jonathan out of Jezreel and his nurse took him up and fled; and it came to pass as she made haste to flee, that he fell and became lame. And his name was Mephibosheth."

But surely you know that up to recent years all polio lesions were attributed to worms, teething or trauma (usually at the hands of a careless nurse). It is obvious that Samuel was simply repeating a popular misconception (another gullible editor!) What happened in this case seems quite clear. Would any sensible woman who was making haste to flee attempt to carry a five-year-old boy if he were fit? Certainly she would not; she would encourage him to run like hell and follow as best she could. The fact that she attempted to carry him shows that he was already ill; no doubt suffering from the "pre-paralytic" stage of polio. No wonder she stumbled and no wonder the subsequent crippling was, as usual, attributed to the fall. Trauma from a simple fall would not have caused permanent lameness of both feet; such crippling is invariably due to polio.

The diagnosis on Vulcan was made on my own responsibility and I still think it to be correct. It is quite obvious that Vulcan himself thought he was born with a disability in his lower limb. In the Odyssey he says:

"O Jove! (he cried) O all ye powers above,
See the lewd dalliance of the queen of love!

Me, awkward me, she scorns, and yields
her charms
To that fair lecher, the strong god of arms.
If I am lame, that stain my natal hour
By fate imposed; such me my parent bore:
Why was I born?"

(Pope's Version Book VIII)

Obviously Vulcan did not associate his crippling with the trauma that he might have received while hurtling through stellar space. As you have pointed out he was flung because he was crippled and not crippled because of the flinging.

Now of course Vulcan only thought he was born a cripple. But we know (don't we?) that there is no congenital lesion causing so much crippling of both lower limbs. Even if he had only club feet as you suggest the answer is still poliomyelitis. But he had much more than simple club feet, for he required two homemade physiotherapists to assist him in walking.

"The monarch's step two female forms
uphold,

That moved and breathed in animated gold;
To whom was voice and sense and science
given,

Of works divine (such wonders are in
heaven)!

2 (Homer. The Iliad Book XVIII, Pope's Version).

Two such elaborate orthopaedic appliances would not be necessary except in the presence of widespread involvement of the anterior horns in the lumbar enlargement.

Like most editors you insist on your passion for truth, and you will therefore be grateful for the unquestionable facts that I have uncovered for you. But let's not be profligate; remember what Mark Twain said:

"Truth is the most valuable thing we have.

Let us economize it."

So I refuse to listen to any more truth on this matter and shall spill no more into your editorial ear.

Yours sincerely,

(Signed) J. D. Adamson.

Now let us consider this letter closely. It begins: "Of course Mephibosheth had poliomyelitis!" That is a truculent pronouncement. It bears upon it the emphasis of one who makes up in dogmatism what he lacks in assurance! It is the sort of statement one makes when he feels in his bones that his arguments are flimsy and are about to be smashed to smithereens; a sort of defiant cry uttered at the moment prior to

annihilation!

Let us look at the evidence. "William Osler made that diagnosis in 1892 and I confirmed it in 1952." Can one make a diagnosis without hearing the patient's story and without going through the essential procedures of inspection, palpation, percussion and (auscultation?) Without these one can infer a diagnosis but cannot make it. I do not say the inference is an unreasonable one—I merely say it is only an inference.

The same procedures are necessary for the confirmation of a diagnosis as are needful for the making of one. Now Dr. Adamson as we all know (don't we?) is very truthful. Therefore he must mean what he says. Somehow he was able to confirm, not an inference but, a diagnosis. How did he do it?

I can think of only three ways. First, he may have succeeded in projecting his astral body into whatever sphere is now inhabited by Mephibosheth. Second, Mephibosheth may have obligingly materialized himself and submitted to investigation. Third, Dr. Adamson had a revelation.

Somehow or other I find it difficult to accept any of these improbabilities. I am therefore forced to the conclusion that his confirmation would not be accepted in any court of law and would not be considered seriously except by some Insurance Company who wanted an excuse for cheating the boy out of his rightful due.

I am fully aware that teething, trauma and trematodes were blamed for many things with which they had nothing to do. I agree, also, that nurses can at times be horribly careless even in this day and generation. But in the case of Mephibosheth, he had got over his teaching and did not, apparently, have worms but he did have trauma — more properly, he had been injured. "Samuel" said the gal dropped him and he should have known.

You will notice that I put "Samuel" in inverted commas because like "the birds that sing in the spring tra-la-la" Samuel had "nothing to do with the case." "It is obvious" writes Dr. Adamson "that Samuel was simply repeating a popular misconception (another gullible editor!)" Another gullible editor, forsooth! That's a dig at me! Is Dr. Adamson so ignorant of the Scriptures as not to know that Samuel had been dead for years before the Mephibosheth incident? The book was only called the Second Book of Samuel. Actually the prophet died in the twenty-fifth chapter of the first Book of Samuel. Theologians differ among themselves as to who was the author of the Second Book but he was, without doubt, a person of the highest credibility.

Nevertheless Dr. Adamson disputes the point. Doubtless that is because of his "revelation" which probably ran thus: "Now, tidings came out of

Jezreel, and when she had heard them the nurse of Mephibosheth went to him and said: Get thee upon thy feet and run like Sheol for verily the enemy is upon us. And Mephibosheth answered her saying: I cannot, for there is a stiffness about my neck, and my head acheth and my back also; and moreover I have a fever. And the nurse saw that it was so and she took him up and fled, etc."

Actually, it is just as likely that the following is the true version. "Now, tidings came out of Jezreel and when she heard them the nurse of Mephibosheth ran to his chamber and said unto him: Climb thee upon my back, for thou art but a little one, and put thine arms about my neck and cling tightly for we must flee. And it came to pass as she made haste to flee that there was a place on the way where there was a pit of the depth of about five cubits. And as the nurse sought to leap over the pit she stumbled, and the arms of Mephibosheth were loosened from their hold and he fell into the pit and became lame."

You see! it was not a simple fall but quite a complicated one. Dropping five cubits is no joke. It's a wonder the little blighter wasn't killed! But there you are, he got off with lameness of his feet.

Here endeth the discussion on Mephibosheth.

Now, let us turn again to l'affaire Vulcan. This time the diagnosis is Dr. Adamson's own. Apparently it has been arrived at by deduction and not by revelation or such like esoteric assistance.

Dr. Adamson says that "Vulcan only thought he was born a cripple." Vulcan states it as a fact. No other explanation he may have held is supplied to us. In any case it would be rather difficult for him in later life to disentangle the various deformities with which he ended up. An object falls through space (if I remember my Physics) at a rate of 118 miles per hour. The unhappy god fell for the whole of a very long day—say for twenty hours (you have to allow for his altitude at the time the fall began). Twenty times 118 is two thousand, three hundred and sixty miles. He must have landed with a devil of a wallop. I completely agree with my correspondent when he writes "he had much more than simple club-feet." He sho had!

It is remarkable that he managed to get along as well as he did. According to Homer he was constantly flying hither and yon and without wings. In fact, his behaviour was that of a victim of hysteria who was continually forgetting to be hysterical.

Dr. Adamson seeks to bolster up his fragile argument with an appeal to the Odyssey. "If I am lame, that stain my natal hour, By fate imposed; such me my parent bore." Now, Vulcan was deformed in his feet before his ejection from Heaven. Did he not give that as the reason of his ejection ("For that I was crippled in my feet?") Because of that reason proud Juno (unnatural mother!)

disliked him. Because she disliked him she kicked him out. Because he was kicked out he got bashed up on Lemnos. Ergo, because of his first deformity, he acquired the others. How polio can be brought into this I do not see.

The insistence of my correspondent stirs me to class him with the physician in Moliere's "Malade Imaginaire" who saw lungs sticking out everywhere. Every symptom mentioned by the patient was followed by the doctor saying "le poumon, le poumon" and when the narration was complete the doctor's conclusion was "Justement le poumon."

And the poet Crabbe had also something to say along the same lines—

"One to the gout contracts all human pain,
"He views it raging in the frantic brain;
"Finds it in fevers all his efforts mar,
"And sees it lurking in the cold catarrh.
"Bilious by some, by others nervous seen,
"Rage the fantastic demons of the spleen;
"And every symptom of the strange disease,
"With every system of the sage agrees."

Is it possible that:

Fell polio's hand Mephibosheth betrays,
And Vulcan, too, who crooked is all ways;
And Oedipus, the Greek, does also show,
The dread effects of classic polio?

(Ye gods! That I should have to break into rhyme!)

The "queen of love" was not repelled by any congenital abnormality which disfigured her spouse. Literally he was a dirty stinker. She was, in a way, an unwilling bride. Besides, though she possessed the face of an angel she had, alas! the morals of a tom-cat. Vulcan's extreme skill as a forger of thunderbolts made him a prime favourite of Jove; and when he asked Jove for the hand of Venus in marriage the Father of the Gods gave his consent. But Venus found nothing to admire in the nasty, misshapen, filthy, unwashed, malodorous smith. Even if she had, it was not in her nature to be faithful for long. As it was, the ink was scarcely dry on her marriage lines before she was misbehaving with Mars. Apparently even to the ancient goddesses there was "something about a soldier." It was quite a combination. Vulcan was crude and rude, and Venus was lewd.

At any rate the curious eye of Sol, peering through her window, found her with Mars, making a hash of the seventh commandment. Of course the old tattle-tale immediately informed Vulcan who flew home to see for himself. (Vulcan seems to be continually flying to some place or other). There he found them flagrante delictu; and, doing another spot of flying, he got to work at his forge where he made a net of such exceeding fineness that it was invisible, but of such exceeding strength that it was unbreakable.

He set up this contraption in such a way that when next the culprits visited the "genial bed"

(which they did when they felt secure) the net fell upon them and held them prisoner. This done, Vulcan invited the gods and goddesses to come and peer and jeer. The ladies refrained out of modesty, but the gods were all there in full force and they viewed the scene with aching sides as they roared with laughter.

Vulcan was not the brightest of the gods but finally it sank into even his dull brain that the laughter was directed mostly against himself, for to his pre-existing deformities had been added the horns of a cuckold. If he had had any doubts upon the matter they would have been set at rest by the conversation Apollo held with Mercury in which the former asked how the latter would feel were he to be so punished, to which Mercury replied that he would enjoy it very much, were he first of all permitted to commit the offence.

This, of course, has nothing to do with polio but rather with love and parthenogenesis. When Vulcan got rid of Venus he picked on Minerva for a spouse. After all, he and Minerva had this in common—each had but a single parent. Jove felt quite taken aback when Juno produced Vulcan. He had his doubts about her story and brooded so much upon it that he developed a most intense headache. The pain got so bad that he sought advice but instead of going to Dr. Apollo or Dr. Esculapius he went to a quack—to wit, Vulcan.

Vulcan held no certificate in neuro-surgery, but he gave Jove a good, healthy thwack on the noggin which laid his skull open and from the opening there emerged, in full panoply the goddess Minerva complete, I have no doubt, with her little white owl perched upon her shoulder.

The fatherless Vulcan, therefore, felt a kinship with the motherless Minerva. But she would have none of him. (No gal, it would seem, wanted to have anything to do with him). He struggled, nevertheless, to possess her and in the struggle "his nature fell upon the earth" and from this sprang Erichthonius who also had polio—I mean who also had deformed feet—and in order to hide his deformity he invented the chariot. (Definitely he had polio—he had to go about in a wheel-chair!)

Thus spurned by the fair sex Vulcan fabricated an extraordinary woman who was named Pandora because so excellent was the workmanship that every god was moved to give her some present. Minerva gave her wisdom; Apollo, the art of music; Mercury, the art of eloquence; Venus gave her beauty, and so on. Jove alone seems to have been displeased and he gave her a box which was filled with all sorts of disasters, but into which Hope in some fashion squeezed herself.

It was therefore no trick for Vulcan to fabricate the golden maidens—the "orthopedic appliances" of Dr. Adamson. These were, perhaps, a little for support but much more for the satisfaction of his ego. "What beautiful specimens of workmanship!"

observers would exclaim and, as he proudly admitted them to be his handiwork, the feeling of unwantedness and of inferiority would fall from him and he would stand admired, as the supreme craftsman.

We have now gone, I think, sufficiently far into the realm of mythology to dispose of any lingering doubts which Dr. Adamson's letter may have inspired. Yet, having gone so far, it would be proper to dispel another assumption which, I imagine, many of my readers hold. How ridiculous, they will exclaim, was the theology of the ancients! How could any sensible people believe in such a religion!

But the theology of the Greeks was far from stupid. It was not, however, direct but symbolical. Vulcan was the god of terrestrial fire, and fire continually requires support even as did the lame god. Venus was the flame, hot, and consuming, capable of melting to softness the hardest natures. The union of Vulcan (the foulest of the gods) and Venus (the loveliest of the goddesses) is therefore not unreasonable.

But Minerva, who is Wisdom, would not bind herself to an armourer for war and wisdom seldom

agree. Moreover Wisdom, being a product of the brain, sprang from the head of the Father of the Gods; her birth thus signified her nature and origin.

The fable of the enmeshing net is likewise reasonable for the bonds of love are as strong as they are invisible and not seldom are forged by deformed and halting passion.

In truth, Vulcan was lame because he was the symbol of fire which continually needs replenishment and support.

Here endeth—that is ENDETH—the discourse on Vulcan.

Let me draw your attention to the last sentence in Dr. Adamson's letter: "I refuse to listen to any more truth on this matter." You will notice that he does not put truth in quotation marks, which is evidence of his realization that what he read upon the subject (from my pen) was actually the truth. He anticipates also my smashing, unanswerable arguments that will sweep away the last vestige of doubt from the minds of all—including himself!

J. C. H.

Letter to the Editor

Three Cheers for Our Side

Dear Doctor Hossack:

In a recent "Review" you asked for contributions.

I cannot write on interesting subjects, such as "The Influence of a Digital Paronychia on a Proctological Diagnosis." Nor can I dip learnedly into mythology to show how Vulcan (or was it Aphrodite?) influenced the writings of Shakespeare.

But there is one bit of information which might interest you. Of 23 graduates of the Manitoba Medical College who wrote on the various State Board Exams in 1952, 23 passed.

This is a 100% record and beats such distinguished schools as Toronto, Johns Hopkins, Stanford, Jefferson, Cornell and Tufts.

If you want to "paint the lily" I might add that the 23 who wrote, were anywhere up to thirty-five years out of medical school; while the other students (excepting Toronto) were largely recent graduates writing in their own states.

The two French Colleges, Laval and Montreal, let Canada down hard.

The over-all foreign-school failures was 46.3%; so give the Buffalo a pat on the back and let the Eagle scream!

No fooling, I enjoy your editorials.

Yours sincerely,
H. P. McPhail, M.D., C.M., '17,
1256 N. Hamilton Street,
Pomona, Calif.

P.S.—M.D. Calif., 1952.

Annual Meeting, 1953

Report of Nominating Committee

The Annual Business Meeting of the Manitoba Medical Association (Canadian Medical Association, Manitoba Division) will be held at the Royal Alexandra Hotel on Friday, October 16th, 1953.

Sessions will be held afternoon and evening in the Colonial Ballroom with a pause for refreshments and dinner to be held in the Tea Lounge (Gold Room), beginning at 6.30 p.m.

The Nominating Committee will present the following report for officers for 1953-54:

President—

Dr. W. F. Tisdale, Winnipeg

1st Vice-President—

Dr. R. W. Whetter, Steinbach

2nd Vice-President—

Dr. Ruvin Lyons, Winnipeg

Dr. David Swartz, Winnipeg

Honorary Secretary—

Dr. J. E. Hudson, Hamiota

Honorary Treasurer—

Dr. J. McKenty, Winnipeg

Dr. L. A. Sigurdson, Winnipeg

Member at Large, Rural: (to complete the unexpired term of Dr. A. S. Little)—

Dr. H. L. McNicol, Flin Flon

Member at Large (Rural: (for 3 years)—

Dr. R. S. Harris, Virden

Dr. G. T. McNeill, Carberry

Member at Large, Winnipeg: (for 3 years)—

Dr. H. E. Bowles, Winnipeg

Dr. A. E. Childe, Winnipeg



"Vaginal leukorrhea" due to *Trichomonas vaginalis* is described¹ as "one of our truly nuisance diseases," being present in *one out of five* women, yet many a woman still hesitates to discuss leukorrheal discharge with her physician.

Physiologic Floraquin® Therapy in Leukorrhea

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Treatment³ has a twofold purpose: To destroy the trichomonads and to keep the vagina dry. Floraquin, with its acid and sugar content, maintains a normal vaginal pH of 3.8 to 4.4 and encourages the growth of the normal Döderlein bacilli and secretions.

Active treatment with Floraquin should be continued⁴ through at least two or three menstrual periods to assure successful cure.

It is available as powder and vaginal tablets.

1. Savage, M. B., in discussion of Davis, C. H., and Grand, C. G.: *Trichomonas Vaginalis* Donné: An Evaluation of Experimental and Clinical Data, *Am. J. Obst. & Gynec.* 64:544 (Sept.) 1952.

2. Upton, J. R.: Symposium: Certain Aspects of Office Treatment in Obstetrics and Gynecology: *Trichomonas Vaginalis* Vaginitis, *West. J. Surg.* 60:222 (May) 1952.

3. Kleegman, S. J.: Treatment of *Trichomonas* Vaginitis, *GP* 6:49 (Aug.) 1952.

4. Kanter, A. E.: The Recognition and Treatment of Vaginal Lesions, *Postgrad. Med.* 12:457 (Nov.) 1952.

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Medical History Club

J. C. Hossack, M.D., C.M. (Man.), Editor

The First Book of the Chronicles of the Medical History Club

Chapter I

1. Now it came to pass on the 12th day of the 5th month and in the one thousand nine hundred thirty and first year of our redemption that there came unto me Bill which is called Gardner and he said unto me: Would it be pleasing unto thee to be one of a company which hath for its purpose the study of the history of our craft?

2. And I answered him saying Yea, verily it would please me much to be of such a company. Tell me, I prithee, be there any such?

3. And he answered and said unto me, Alas there be none. Then I said unto him, Be of good cheer for that which is not is that which shall be and speedily.

4. And when I had said this I gat me unto my chamber and pondered upon the matter. Then spake I upon the instrument of two strings unto such as might be of a like mind.

5. And I asked them whether it be yea or nay and they answered me saying: Go to. Let it be even as thou hast spoken.

6. And these be they to whom I spake upon the instrument of two strings. There was John surnamed Brodie,¹ he who understandeth the movements of the heart; and John surnamed Gunn who was afore time High Priest in the Temple.² And Jaydee son of Adam, the same that is High Priest in many temples.

7. And Ross surnamed Mitchell who bringeth forth the begettings of many men and for whom women cry in the hour of travail. And Fred who remaineth Young even though his years increase.

8. And Bruce surnamed Chown the same that disemboweled the dead and called upon their spirits to rise from the tomb.³ And we rejoiced that he was of us for we said Peradventure he will bring unto our meetings the spirits of them of whom we speak.

9. And Harry commonly called Speechly⁴ the same that sitteth upon the bodies of them that are dead and who slaughtereth with a mighty slaughter the Children of Culex and the Tribe of Anopheles.

10. And Alvin surnamed Mathers, the same that is now Chief Priest⁵ and who understandeth all the mysteries of the soul, yea and of the id and of the ego and of the superego.

11. Unto all these spake I upon the instrument of two strings and they answered me every-one saying: Amen. So be it.

12. And when I had made an end of this matter I returned unto Bill which is called Gardner and spake unto him saying:

13. Behold I bring thee tidings of great joy for that which was not is that which is, namely a Club and the name thereof shall be the Medical History Club.

14. And Bill was astonished and he uttered sounds of joy, yea, he opened his mouth and cried in a loud voice Halleluiah.

15. And I said unto Bill surnamed Gardner, Peradventure it were fitting that the brethren be called together.

15. And Bill answered me saying Thou speakest sooth. Let there be such a coming together and let it be on the even of the day after the morrow. And it was so.

17. And when the day after the morrow had come certain of the brethren did gather together even John surnamed Brodie and Bill surnamed Gardner and I also was among them.

18. Then John surnamed Brodie stood forth in the company and opened his mouth and spake unto us saying: Men and brethren, it is fitting that all things be done decently and in order. Wherefore I beseech ye, as many as are here present, to make a writing which is a constitution whereby we shall all be governed now and for ever more. And we said Amen.

19. Then did John surnamed Brodie bring forth a scroll and showed it unto us and we looked upon it and saw that it was a constitution and we studied it diligently and saw that it was good.

20. And when we had done this Bill which is called Gardner opened his mouth and spake unto us saying: Let there be another coming together of the brethren whereat some one of us do speak upon a matter.

21. And we answered him saying: Even so and let it be thou that speakest and may the joints of thy tongue be loosened so that thou shalt speak fittingly upon a matter.

22. And Bill answered us saying: Let it be even as ye will. And we departed.

Chapter 2

1. Now when the days were accomplished that Bill should speak unto us there was a great coming together of the brethren.

2. And they came unto the house of Bill and tarried there for a season.

3. And when they were assembled Bill stood forth and spake unto them saying: Sirs and brethren, a great thing hath come to pass among us, for behold we are a Club, and it is meet that we should do those things that are proper, which is a christening.

4. Therefore I call upon ye all to follow me as I drink of this cup so that our fellowship may prosper. Then brought he forth certain vessels and a bottle of rich and precious wine and he poured it forth for us and bade us drink saying Be ye filled with the spirit.

5. And we partook of the wine and it was of a sweet smelling savour in our nostrils and the taste thereof was as the wine of Scotia and as the honey which filleth the honey combs in the hills of Lebanon.

6. And when we had emptied our vessels the joints of our tongues were loosened and all things were pleasing unto us.

7. Then did Bill surnamed Gardner bring forth a great book and he opened it unto us. And we saw that it was writ in a strange writing and we understood it not.

8. And we said unto him: Tell us, oh Bill, we pray thee, what meaneth this? And Bill said unto us: Behold this is the writing of them that dwelt aforetime in the Land of Egypt. And in the tongue of the vulgar, one calleth it the Papyrus of Smith.⁶

9. Now they that wrote it were scribes which were also cheirurgeons and they were cunning men for they knew that there was a time to cut and a time to refrain from cutting and this is to be accounted unto them for wisdom.

10. For even at this hour and among our own kindred there be some who have not that wisdom but who cut whenever the spirit moveth them which is often. Nor will they stay their hand save peradventure he who is sick lacketh the wherewithal.

11. And such be but mere hewers of flesh and drawers of blood. And they be not true cheirurgeons but, as it were, bastards and such have no wisdom.

12. Then spake he much about them that dwelt in the Land of Egypt. And we were astonished that they had such knowledge albeit cheirurgery be but the trade of a craftsman.

13. And when we had made an end of speaking upon the matter we hied us unto an inner chamber and sate us down at a table whereon were rich cakes and we did eat thereof and we did drink of the juice of the grape and of the barley, and a maid-servant brought unto us vessels filled with water wherein had been steeped certain fragrant herbs.

14. And we pledged our fellowship therein and the smell of incense was strong in our nostrils. And after we had tarried about the space of three hours we said: Behold, this is a goodly fellowship. And we departed.

15. And this is the beginning and the ending of the first session for there were no more meetings in that session.

Chapter 3

1. Now it came to pass thereafter that there were many meetings, yea from the 9th month even to the 5th month did we meet. And we learned many things that it was fitting that we should know.

2. But of these things I say nothing for verily are they not to be found in the Scroll of the Chronicles of Matters Whereon We Spake? And there they are to be seen even unto this day.

3. And in those days we came together in the habitation of him who spake.

4. And the fame of our brotherhood was spread abroad so that certain persons came unto us saying: We hear ye have a goodly fellowship whereof I would fain be one. Tell me I pray ye what must a man do to enter this fellowship?

5. And unto these we made answer saying: Ye are very welcome and the brethren will rejoice to receive ye into our company. And ye may enter without money and without price so be it ye give your reasonable service which is to come faithfully and speak unto us when ye be asked so to do.

6. And among them that came unto us at that time were Monty⁷ who was aforetime High Priest of the Physicians, and Harvey surnamed Smith, he who for a season was Chief Ruler of all the physicians in the lands of the Great King.⁸

7. And David surnamed Stewart.⁹ And he was a mighty man and he bore upon his shield the cross of two arms, and he fought valiantly against the Captain of the Men of Death and discomfited him sorely so that now he no longer frighteneth us.

8. And we were sore grieved when he was gathered unto his fathers for few there be like unto him. But he hath left his memorial behind him and his name will not be blotted out.

9. And about the same time there came unto us Alec. surnamed Cameron¹⁰ who speaketh not as did his fathers but with the tongue of them that dwell in the city of the Great King. And it is he that gazeth upon the entrails of rabbits and sayeth unto one woman: Be of good cheer for thou art not so. And unto another: Verily that which thou didst fear hath come to pass.

10. And there came unto us also Noel, son of Raw, and he spake unto us upon a matter about the space of three hours.

11. And all these spake unto us upon sundry matters and we received them with joy into our company.

12. And in those days we gathered in the habitation of him who spake and they regaled us ere we departed.

Chapter 4

1. Now it came to pass that Bill surnamed Gardner was sore at heart for that the fellowship grew not in numbers. And he said unto the

company: Wherefore are we so few?

2. And the brethren pondered diligently upon the matter for verily our numbers grew not and our hearts were saddened.

3. And Bill surnamed Gardner spake again saying: Peradventure it were better if we came together in the upper story of the House of Physicians. For there could we break bread and others with us and moreover the space thereof is greater than in our habitations.

4. And the brethren saw that this was good and said: So be it. And so it came to pass that we came together in the upper storey and broke bread at the 7th hour and afterwards we harkened to the discourse of the brethren.

5. And Bill which is called Gardner spake again to the brethren and said: Let those among ye who have knowledge of any of a like spirit with ourselves bring them unto our meetings so that our numbers be increased. And the brethren answered him saying Yea we will do so.

6. And there came sundry persons to our meetings. And some came one time or peradventure two times but then no more for our spirit was not in them.

7. And it came to pass that our numbers were still but a few when one of the brethren stood forth in his place and spake unto us saying: Peradventure we should have over us a ruler (for there had been no ruler over us from the beginning).

8. But another of the brethren said: What shall it profit us to have a ruler over us? Let him that speaketh a discourse rule over us for the space of a moon thereafter and so shall we all be ruler in turn. And the brethren said: So be it.

9. And another of the brethren stood forth and said: Have we not a scribe? Let him bear the toil and anguish and upon him let us lay the blame when things go not well? And there was laughter.

10. But I, the scribe, rose in my place and spake unto the assembly saying: My masters, Verily I am a man of sorrows and acquainted with grief, yet lay not, I beseech ye, this burden upon my shoulders but let me have two of the company for my councillors and to give me succor. And for their reward let them have the praise when things go not ill.

11. And they questioned me saying: Whom wilt thou have to aid thee? And I said unto them I will have Bill surnamed Gardner and Ross surnamed Mitchell so be it they are willing. And Bill surnamed Gardner and Ross surnamed Mitchell said, Verily we will go with thee for thy guide in thy most need to be by thy side.

12. And so it came to pass that we three met together and our hearts were heavy within us for that our numbers were few. And we pond-

ered upon the matter.

13. And there came unto me a thought which I held fit for to utter. And I said: What think ye of this? Let us gather together the books which deal with ancient things and which are now in the Room of Books in the Temple and let us set them apart in a chamber and upon the walls of the chamber there shall be drawings and paintings of our fathers in our calling. And let us moreover gather those things that belonged unto them that practiced our craft in this land even from the beginning.

14. And all these things shall be together and in one chamber in the Temple of our craft. And the disciples shall go therein and they shall learn the deeds of their forefathers and meditate thereon. And it shall nourish their souls and make them to strive even as their forefathers did strive against those things which send man unto his long home out of his due season.

15. And let us furthermore keep fresh the memories of them that builded our temple and of them that were priests therein even from the time of its building and before that for the iniquity of oblivion blindly scattereth its poppy and it is not fitting that those worthy of memorial should be forgotten.¹¹

16. And they to whom I spake said: Thy thought is a good one. Go, then, unto the Keepers of the Books and say this thing unto them.

17. And it came to pass that I appeared before the keepers of the Books of the Temple and the Chief Keeper was Dan son of Nichol.

18. And I spake unto him and he answered me saying: Verily what thou hast said is very good and peradventure we may do the things that thou desirest. But tell me, has thou many sheckels?

19. And I said unto him: What need be there of sheckels? And he answered me saying There shall be need of shelves whereon to set the writings and thou shalt need also cases wherein to place the things that thou shalt gather and for these thou shalt need many sheckels.

20. And I was wroth and I said unto him: In our fellowship we speak not of such things but of more noble things, nor forsooth have we any sheckels, nor doth it seem to me needful that there be more than a few small pieces of silver for what we require. And moreover rare and precious books will be given into thy keeping whereby thou wilt be enriched. But he harkened not unto me but only lifted his shoulders and said: Come unto us again and we shall speak to thee so be it thou canst tell us that thou hast the sheckels.

21. And I departed exceeding sorrowful yet nevertheless I held within me the hope that this thing might yet be.

Chapter 5

1. But there came unto us others in whom was our spirit so that our numbers did increase. And amongst them were Larus son of Sigurd who is of the seed of Thor and Wodin.

2. And Gerard son of Alli and he was faithful in his coming but he took unto himself a wife and now he goeth not forth in the evenings. And Ian son of Thom, the same that maketh the dry bones to live even as it was in the vision of the Prophet Ezekiel.

3. And John surnamed Hillsman who cometh from a far country wherein the people be of many colours. For amongst them be Scarlett and Rhett and many be of the hue of the Ethiopian.¹² And he persisteth in saying Edinburg which is an abomination and an offence in the ears of all the Children of Caledonia who know that the name thereof is Edinburra. And fain would we have him desist from this fault.

4. And also there came David surnamed Swartz, he who cutteth for the stone; and Simon called Jauvoish who is a writer of books and these be of the tribe of Judah. And Digby surnamed Wheeler who peradventure likewise is of the tribe of Judah for verily he gathereth great riches.

5. And all these spake unto us and have abided with us. And they who were of us from the beginning likewise left us not but spake unto us some one time and some twice and some, peradventure, three times. But Bruce surnamed Chown came not for he said My spirits come not wheres ye are.

6. But John surnamed Gunn whensoever he spake unto us did bring with him certain choice and ardent spirits¹³ which entered into us. So that the brethren would say: Tell us, we pray thee, when shall we hear again John surnamed Gunn, for his discourse is pleasing unto us but not his discourse only but likewise the spirit with which it is given.

7. And John surnamed Gunn left us for a season for like Peter's wife's mother he lay sick of a fever. And the cheirurgeons laid hands upon him so that there might be fulfilled the saying: Whoso sheddeth man's blood by man shall his blood be shed.

Chapter 6

1. Now it came to pass that the fame of our fellowship was spread abroad so that it came unto the ears of the Chief Ruler of the Society even Fred surnamed McGuinness. And it is he who is a mighty wielder of the tongs and is moreover chief Guardian of the Tentorium. For he sayeth: It is given unto many men to repair the perineum but who be there among ye that can mend the tentorium?

2. And Fred said unto me: Were it not well that thy fellowship and mine be one? And I

considered the matter and said: Verily thy saying is true and worthy of all acceptance and I shall tell it unto the brethren. And I did so and the brethren said: Verily let us do this thing.

3. And certain of them set their names unto a writing wherein was set forth our desire to become one with the Society. And our writing was read in the Council of the Elders¹⁴ and they blessed it and said So let it be.

4. Then did it become needful for us to have a chief ruler and he who was ruler at the time said unto the brethren: Whom will ye have for your ruler?

5. And the brethren cried in a loud voice and as one man: We will have Bill surnamed Gardner to be our ruler, and may his shadow never grow less, and may he live for ever and ever.

6. And when Bill was seated on the high place he spake unto them saying: Brethren, we have need also of a scribe and one to speak for us in the Council of the Elders.

7. And the brethren said: Let him who hath been our scribe from the beginning be so even now, and let him sit in the Council of Elders and speak for us therein.

8. And there was a clapping of hands and it was so.

9. And so it came to pass that the brotherhood became a section of the Society. Wherefore have I written these things that they perish not from our memories.

Chapter 7

1. And unto them that shall come after us say I this. I pray, yea with all my heart and with all my soul do I pray and the brethren likewise, that ye let not this thing perish at your hands, but cherish it and foster it till it become a great thing among ye, for so shall ye prosper.

2. For it is a sweet and a beautiful thing that ye should come together to praise famous men and the fathers that begat ye.

3. Let not their glory be blotted out but set their light upon an high place where it can be seen of all men and more especially of those youths and maidens that be your disciples, so that they may ponder thereon and sware that they shall bear themselves worthily as becomes such high lineage.

4. And, I beseech ye, let there be among ye neither Jew nor Gentile, Barbarian nor Greek, but brethren only; for our craft knoweth not a man by his garments or by the temple wherein he prayeth but is one fellowship. Shut not thy door, therefore, against any man that would enter, so be it he is worthy.

5. And may the spirit of Imhotep the Egyptian, and Hippocrates the Greek, and Avicenna the Arab and Maimonides the Jew and all others our fathers be with you. And may this fellowship prosper at your hands and may it endure for ever

and ever.

6. Behold, I have finished.

Notes

Many present-day readers will not understand references that needed no explanation at the time these Chronicles were written. For that reason the following notes have been appended.

1. John Brodie. A most erudite member of the staff of St. Boniface Hospital, specializing in cardiology. He now lives in California.

2. High Priest—professor. Dr. Gunn was Professor of Surgery.

3. Bruce Chown was pathologist at the Children's and Grace Hospitals. He was interested in Psychic Research.

4. Dr. Speechly was coroner and also the moving spirit in Mosquito Control.

5. Chief Priest—Dean of Medicine.

6. The Surgical Papyrus, a transliteration and translation of which had just been published.

7. Dr. E. W. Montgomery who was Professor of Medicine, and the first Minister of Health in the Province.

8. In 1930 the B.M.A. and C.M.A. had a joint meeting in Winnipeg. Harvey Smith was president of both.

9. Dr. David Stewart launched the campaign against tuberculosis and was largely responsible for its successful conduct.

10. Professor A. T. Cameron, the biochemist, was a Scot who, because he was brought up in England, spoke as a Londoner and with no Scots accent. He introduced the Ascheim-Zondek Test and performed it here.

11. I wanted to convert the Board Room in the College Building into a "Shrine" where mementos of the college founders, of the early practitioners and so on might be housed. The Library Committee, however, was not tradition-minded and nothing was done.

12. Dr. Hillsman is a Virginian. At the time the motion picture of the year was "Gone With the Wind," in which the chief characters were Scarlett O'Hara and Rhett Butler. (P.S. He still calls it "Edinburg").

13. Usually "Johnny Walker."

14. Council of Elders—Executive Committee of Winnipeg Medical Society.

The Second Book of the Chronicles of the Medical History Club

(Which is an Epistle)

Chapter 1

1. John, which was aforetime scribe unto the brotherhood of them that took pleasure in discoursing upon the doings of our fathers in our craft, unto all those who be of a like mind: Greetings and peace.

2. First, I would have ye know all that hath befallen our fellowship since it became a part of our greater fellowship which is our Society.

3. For a season it prospered, so that many came to hear what was said, and of themselves, to speak also.

4. But it came to pass that an ungodly man arose in a far country and there was given unto him great power to do evil; and he set the world on fire, so that all men everywhere went in terror or in anger.

5. And he belched forth the vomit of his hate over many countries and poured upon them fire and brimstone, and set fire to their cities; and the weapons of death were without, and famine and pestilence were within; and they who died not in the fields were destroyed in the cities, the young man and the virgin together with the man of gray hairs; and ruin and desolation were every where.

6. And, verily, it seemed as if the time of the end had come; for disaster followed upon disaster, and the fear was great that we should all be overwhelmed and crushed under the heels of evil men.

7. And throughout all the lands of the Great King men girded themselves to battle, and among them were brethren of our fellowship, so that our numbers were lessened. And, moreover, there was in us little spirit to discourse upon the doings of our fathers, seeing how much was even now to be done by their children.

8. Therefore we gathered not together as had been our wont, but awaited the time when peace should have returned to the earth, should that time ever be.

Chapter 2

1. Now the time came when the hosts of the evil men, who sought our destruction, were utterly discomfited and set at naught. Yet even in that hour was I stricken and laid aside for a season. And it seemed as though none other of the brethren would take upon himself my burden in this matter, so that our fellowship languished and there were no comings together of the brethren.

2. And it grieved me that such things should be yet could I do naught. Yet I strove to keep alive a small spark so that the fire might not utterly be extinguished.

3. And this I did by setting forth certain matters in writing, and they who read them said unto me: Go to. Let us have more of this. And I was comforted thereby.

4. Moreover, when my sickness had abated, I with others of the fellowship, did stand before the youths and maidens that were our disciples in our craft and we spake unto them about their fathers and their great works aforetime.

5. And this we did for a season. But when I was stricken again this also ceased and naught was said upon the matter save only those writings

whereof I have spoken. And, verily, it would seem as if the life of our fellowship had gone from out of it and it was but a dead corpse.

6. Yet there lingereth within it a feeble spark the which will grow unto a flame so be it some one doth fan it. And so it promiseth to be.

7. For there hath come unto me David called Swartz who now ruleth over our Society and was one of us aforetime.

8. And he said unto me: Were it not fitting to bring our ancient fellowship to life again? And I answered him saying: Yea, it is even so, and I shall strive thereto; for verily these things whereof we spake are like to be forgotten which were a sorry thing.

9. And others, also, came unto me saying: Behold, if this fellowship come again into being, count me of the number. And I was heartened.

10. Wherefore write I unto ye at this time, praying that all of ye to whom these words may come and who have within ye a like wish, do come forward and say so unto me; and we shall meet at a convenient season and discourse again upon those in whose footsteps we follow.

11. And I beseech all ye who desire to be with us to send me a writing so that, when the time cometh, ye will be with us when we meet.

12. And, verily, my heart singeth within me for this is a goodly thing and not to be forgoten.

13. And the brethren will welcome into their midst not only those among ye who have been admitted into the fellowship of our craft but those also who still sit at the feet of their masters.

14. And we shall gather together as aforetime in the House of the Physicians in the upper storey thereof, and shall break bread, and hearken into the discourse of them that speak, even as we did in times past.

15. And so that things may go well let each one send even now his writing so that he will be with us at the appointed time.

16. Grace and peace be unto ye all. Given under mine own hand at my place of healing in the House of the Physicians.

First Meeting of the Section on the History of Medicine

The Section on the History of Medicine will renew its meetings in September.

* Everyone who is interested is asked to notify me, preferably in writing, as early as possible so that plans may be laid. The first meeting will be in September.

J. C. Hossack.

Victorian Order of Nurses

A 73-year-old, semi-invalid is leading a happy, useful life today because a Victorian Order nurse accidentally sat in a basin of luke warm water.

The nurse's unhappy accident changed her from an embittered, un-co-operative patient to a cheerful woman no longer resenting the fact that she is alive. This is one of the many cases where the V.O.N. has provided an invalid with the will to live.

The woman—we'll call her "Mrs. G." became an invalid after an active life during which she was a tower of strength and enthusiasm to her family.

Her daughters received tears and rebukes in their efforts to help her after she fell ill. A friend suggested that she be hospitalized, but a bed was not available. Another friend suggested that the V.O.N. be approached to find the easiest way to care for her.

Under the direction of a V.O.N. nurse the woman's bed was raised by blocks to make it easier for the 200-pound woman's daughter to help

her. A bed-tray was made by a son-in-law and a back rest was attached to the bed.

But, "Mrs. G." refused to co-operate and became even more embittered. The V.O.N. nurse was almost ready to admit defeat.

However, one day the nurse and one of the daughters were attempting to straighten and tighten the drawsheet on the bed. The drawsheet was improvised from an old sheet and was not strong.

After the nurse and the daughter had pulled the sheet taut it ripped down the centre. The nurse fell back and sat in a chair on which she had placed a basin of water.

The dripping, embarrassed nurse was about to sputter an apology, when she heard deep chuckles from the bed. "Mrs. G." gasped. "Don't worry about the sheet. It was worth it to laugh again."

A few weeks later "Mrs. G." still an invalid was able to move about in a wheel chair. Her first job in her new-found existence was to knit a pair of socks for her son-in-law. A good hearty laugh had given her the desire to enjoy life once more.

Winnipeg Medical Society

Reported by R. H. McFarlane

The Winnipeg Medical Society

The annual business meeting of the Society was held on Friday, May 15th, in Theatre A at the Medical College. One is very much impressed, but entirely unfavourably, by the very small attendance at this meeting.

At the beginning of the programme, Dr. P. H. Thorlakson gave a progress report on the fund raising campaign for the Children's and the Winnipeg General Hospital, which indicated that a very excellent response was being made by the medical profession. Dr. C. W. Burns spoke briefly to remind the meeting about the oncoming Canadian Medical Association Convention in Winnipeg in June. He gave a very brief resume of the expected programme and activities and extended a very cordial invitation for all members of the Winnipeg Medical Society to attend.

A large portion of this meeting was given over to the presentation of reports from Secretary and Treasurer, standing committees and Trustees of the various sections of the Society. Three of these reports in particular deserved special attention. The report of the Civil Defence Committee, given by its Chairman, Dr. R. A. Tanner, consisted of a comprehensive review of the tremendous amount of work done by his committee and was very well received. Dr. Marjorie Bennett gave a report as representative of the Winnipeg Hospital Service Association and there was some discussion here concerning patients not receiving the full benefits to which both they and their physicians felt they were entitled. Dr. W. F. Tisdale reported on the state of the Winnipeg Medical Society Benevolent Fund and remarked that the income of the fund and the scope of its work could be greatly increased by making it a function of the Manitoba Medical Association instead of the Winnipeg Medical Society only. This suggestion met with the unanimous approval of the meeting. The full reports as they were read at the meeting will be published elsewhere in the Review.

The following officers were elected for the year 1953-54: President, Dr. David Swartz; Vice-President, Dr. F. Hartley Smith; Secretary, Dr. Earl Stephenson; Treasurer, Dr. Dwight Parkinson; Trustee, Dr. Gordon P. Fahrni.

The following were awarded life memberships in the Winnipeg Medical Society: Dr. F. G. McGuinness, sponsored by Dr. Elinor Black; Dr. J. D. Adamson, sponsored by Dr. Sanger McEwen; Dr. Charles Hunter, sponsored by Dr. Lennox Bell and Dr. I. Pearlman, sponsored by Dr. A. Hollenberg. One always enjoys this particular aspect of the Annual Meeting. For as long as I can remember,

those accepting life memberships have always proven capable of providing brief but interesting and humorous acceptance speeches.

The final item on the programme was a paper by the retiring President, Dr. Arthur E. Childe, dealing with the problem of intussusception in infants and the reduction thereof by the use of the Barium enema. This was an excellent and informative paper which will be published in the Review.

Committee Reports

Report of the Secretary

*To the President and Members of
The Winnipeg Medical Society:*

IN MEMORIAM:

Our Society observes with regret the passing away of eight of its members:

Doctors Walter G. Campbell, Thomas H. Cuddy, Clifford R. Gilmour (Life Member), Baldur H. Olson, R. Rennie Swan, David R. Williams, Alexander R. Winram (Honorary Member).

MEETINGS:

The Society in the last year held eight regular and two special meetings. Dr. Hamilton, Sir Stanford Cade, Professor Windeyer and Mr. Gibbard, all of London, England, and Dr. Hugh Morgan of Vanderbilt University, discussed scientific subjects. Dr. Wride came from the Department of National Health and Welfare to speak about Federal Grants for public health purposes. Dr. McMorris, Neepawa, related his experiences with Moscow Medicine.

This year the Winnipeg General Hospital entertained a very large number at its hospital programme meeting for the Society. One regular meeting was shared with the General Practitioners' Association and one special session formed part of the University Post Graduate Course.

Attendance at regular meetings averaged 75.

The Council of the Society met on ten occasions.

CIVIL DEFENCE:

A strong committee, headed by Dr. A. R. Tanner, was appointed to plan and co-ordinate the medical aspects of Civil Defence.

Respectfully submitted.

Earl Stephenson,
Secretary.

Treasurer

*To the President and Members of
The Winnipeg Medical Society:*

Herewith certified financial statement from our auditors, Messrs. Thornton, Milne and Campbell.

All of which is respectfully submitted.

Dwight Parkinson,
Treasurer.
Winnipeg, 6th May, 1953.

*To the President and Members,
The Winnipeg Medical Society.*

Dear Sirs:

We have examined the accounts of the Society for the year ended 30th April, 1953, and submit herewith our report thereon together with the following relative financial statements:

EXHIBITS:

- "A" Statement of Revenue and Expenditure for the year ended 30th April, 1953.
- "B" Balance Sheet as at 30th April, 1953.

Revenue and Expenditure

The operations for the year, as set forth in Exhibit "A," have resulted in an excess of revenue over expenditure of \$1,614.20. Membership fees received are in accordance with duplicate receipts examined by us but are not subject to further verification. Adequate vouchers have been examined in substantiation of all expenditures.

In accordance with the minutes of the Council Meeting of 12th January, 1953, the sum of \$1,000.00 has been placed in the special Library Fund for the use of the Library Committee of the Faculty of Medicine. A statement of the transactions affecting this account during the year is shown on Exhibit "A."

Balance Sheet

In our opinion the balance sheet submitted and marked Exhibit "B" is properly drawn up so as to exhibit a true and correct view of the state of the affairs of the Winnipeg Medical Society as at 30th April, 1953, according to the best of our information, the explanations given us, and as shown by the books of the Society. We have received all the information and explanations which we have required.

We obtained from The Bank of Toronto verification of the bank balances, subject to allowance for outstanding cheques as shown by the books.

During the year your bond holdings were increased by the acquisition of Government of Canada 3 3/4 % 1978 bonds of a par value of \$1,500.00. As at 30th April, 1953, the Society's investments are as follows:

Par Value	Cost	Market Value
\$1,000.00 Government of Canada 3% 1957,	\$1,000.00	\$ 982.50
4,000.00 Government of Canada 3% 1966,	4,042.50	3,730.00
1,500.00 Government of Can. 3 3/4 % 1978,	1,473.75	1,468.13
\$6,500.00	\$6,516.25	\$6,180.63

These securities have been placed in a safety deposit box and were presented for our examination. The bonds registered as to principal only are at present being exchanged for fully registered bonds. All interest, on a received basis, has been duly accounted for on the books of the Society.

In so far as we have been able to ascertain all liabilities applicable to the year under review have been recorded on the books.

In conclusion we wish to express our appreciation of the courtesies extended to us during the course of our audit.

Yours very truly,

THORNTON, MILNE & CAMPBELL,
Chartered Accountants.
Exhibit "A"

Statement of Revenue and Expenditure For the year ended 30th April, 1953 General Funds

REVENUE

Annual Dues:	
Current Year—Active Members	\$3,380.00
Associate Members	20.00
Prior Years	261.00
	3,661.00
Bond Interest	150.00
Less: Accrued Interest	3.85
	146.15
	\$3,807.15

EXPENDITURE

Audit Fees	25.00
Bank Charges	11.70
Catering	111.23
Donations	212.00
Entertainment	54.20
General Expense	62.30
Lantern Slides Expense	55.00
Manitoba Medical Association—Office	
Salaries and Expenses	1,100.00
Printing, Stationery and Postage	409.52

Speakers—Honoraria	125.00
Telephone Expense	27.00
	2,192.95
Excess of Revenue over Expenditure	\$1,614.20

Library Fund

REVENUE

Appropriated from General Surplus	\$1,000.00
Bank Interest	11.72
	\$1,011.72

EXPENDITURE

Books Purchased	160.07
Library Supervision	232.00
Maintenance, Binding, etc.	354.15
	746.22
Excess of Revenue over Expenditure	\$ 265.50
	Exhibit "B"

Balance Sheet as at 30th April, 1953

ASSETS

Cash:	
On deposit with the Bank of Toronto	\$1,637.37
Investments—at cost:	
Government of Canada Bonds	6,516.25
	\$8,153.62
Special Library Fund:	
Cash:	
On deposit with the Bank of Toronto	1,234.46
	\$9,388.08

LIABILITIES

Membership Fees Paid in Advance	\$ 40.00
Surplus:	
Balance as at 30th April, 1952	\$7,499.42
Add:	
Excess of Revenue over Expenditure, per Exhibit "A"	1,614.20
	\$9,113.62
Less:	
Appropriated for Library Fund	\$1,000.00
	\$8,113.62
Special Reserve—Library:	
Unexpended balance 30th April, 1952	968.96
Add:	
Excess of Revenue over Expenditure, per Exhibit "A"	265.50
	1,234.46
	\$9,388.08

Report of Trustees

To the President and Members of
The Winnipeg Medical Society:

As Senior Trustee, I wish to report the following securities as being held in Safety Deposit Box, Bank of Toronto, 394 Portage Avenue:

Dominion of Canada Bond, 3%, 1957	\$1,000.00
Dominion of Canada Bond, 3 3/4 %, 1966	1,000.00
Dominion of Canada Bond, 3%, 1966	1,000.00
Dominion of Canada Bond, 3%, 1966	1,000.00
Dominion of Canada Bond, 3%, 1966	500.00
Dominion of Canada Bond, 3%, 1966	500.00
Dominion of Canada Bond, 3 3/4, 1978	1,000.00

Dominion of Canada Bond,
3 3/4%, 1978 500.00
.....\$6,500.00

Balance on Deposit, Bank of Toronto, as
at April 30th, 1953\$1,637.37

The aforesaid Bonds and Bank Deposit have been vouched
for in Auditors' Report.

I have personally inspected the office equipment of the
Society at 604 Medical Arts Building, the equipment in the
Manitoba Medical College in the custody of the Caretaker, and
Lantern in care of Mr. Gordon Axtell, and found them to
be as listed herein:

Office Equipment at 604 Medical Arts Building:

1 Steel Filing Cabinet, 3 Drawers; 1/3 Interest in Elliott
Addressing Machine; 1/3 Interest in Mimeograph Machine;
1/3 Interest in Underwood Typewriter, 14" Carriage, Serial
No. 5732553-14; 1/3 Interest in "Copy-right" Holder, 1/3
Interest in Burroughs Adding Machine.

Equipment in Manitoba Medical College in custody of Care-
taker:

12 Wooden Chairs; 4 Wooden Trestles and 2 Wooden
Table Tops for same; 32 Cups and Saucers; 1 Coffee Urn;
1 Gavel—This Gavel made from wood from the ruins of
the Royal College of Surgeons and presented to the Win-
nipeg Medical Society by Dr. John C. Hossack; 1 Plaque—
Honour Roll of Past Presidents (in Physiology Lecture Room
of the Medical College). Book value \$218.64.

In Care of Mr. Gordon Axtell:

1 Delinescope Lantern, Model OJR, 3647, made by Spencer
Wells Co. of Buffalo, New York, and one spare bulb for
same.

L. R. Coke,
Senior Trustee.

Membership Committee

To the President and Members of

The Winnipeg Medical Society:

The total membership for the 1952-53 season is 422, made up
as follows:

Active paid-up members	316
Active paid-up members, half rate	42
Associate paid-up members	7
Non-Resident paid-up members	3

Total paid-up members	368
Life Members	21
Free Membership—65 years and over	22
Membership Fees Unpaid	11

Total Membership 422

Twenty-five new members have been added to the roll
during the year.

Seventeen members have been lost to the Society in the
past year, 8 by death and 9 have left the province.

Total membership for 1951-52 was 433 as against 422 for
the current year, a loss of 11 members.

Total paid-up membership for the current year is 368 as
against 347 for 1951-52, a gain of 21 members, and the num-
ber of fees unpaid this year is only 11 against 62 last year. A
large number of arrears have been paid up.

Due to the efficient re-organization initiated and completed
by the membership committee of last year, the paid-up mem-
bership has reached a high level. It is only fitting that the work
of the previous committee be recognized and commended.

All of which is respectfully submitted.

Matthew K. Kiernan,
Chairman.

Programme Committee

To the President and Members of

The Winnipeg Medical Society:

The following is the report of the Chairman of the Pro-
gramme Committee of the Winnipeg Medical Society for the
year 1952-1953.

During the past year the Winnipeg Medical Society has
held seven regular meetings and two special meetings. The
following local speakers presented papers: Dr. Jan Hoogstraten,
Dr. Arthur I. Lerner.

In addition, papers were presented by the following guest
speakers: Sir Stanford Cade, Professor Richard M. Windeyer,
Dr. Gordon E. Wride, Dr. L. S. McMorris, Dr. Hugh Morgan,
Professor W. J. Hamilton.

The two special meetings included the meeting held in
conjunction with the Refresher Course of the University of
Manitoba Faculty of Medicine on April 14, 1953, at which
Dr. Hugh Morgan was the speaker and our first meeting
of the year held on September 12, 1952, at which Sir Stanford
Cade and Professor Richard M. Windeyer were guest speakers.
In addition to this there were two panel discussions held
under the chairmanship of Dr. J. M. Lederman and Dr. D. L.
Kippen respectively. The annual hospital meeting was held
as usual in January of this year. The staff of the Winnipeg
General Hospital organized a most successful evening. The
regular meeting in March, 1953, was held in conjunction with
the meeting arranged by the General Practitioners' Association.
It was at this meeting that Dr. Gordon E. Wride spoke about
"Some Aspects of National Health Insurance."

The retiring Chairman is in agreement with the views of
his predecessor that at least two round table discussions should
be held annually. These meetings are very popular. In previous
years one meeting has been held under the auspices of the
Pre-Clinical Years of the Medical College staff and another
has consisted of papers by the members of the Department of
Physiology and Medical Research. This was not considered a
good policy by our Committee, this year, as may be noted
from the review of the programmes, neither of these meetings
having been held. However, we think it would be a good
policy in the future to have one of these two meetings a year.
This meeting might be made to alternate annually between
the Pre-Clinical Years and the Department of Physiology or
might be held annually as a joint meeting, whichever is more
easily arranged. This was a most unusual year for the Pro-
gramme Committee as so many visiting noteworthy medical
personalities were available as guest speakers that only four
programmes were produced by local talent, two of these being
papers and two being panel discussions.

Following the advice of the previous Programme Committee
a tentative programme for the whole year was drawn up in
August, 1952. This we think is a very good idea but it must
be remembered that this programme has to be extremely
flexible as it will probably be subject to half a dozen or more
changes. It is the opinion of the retiring Chairman that one
person can handle the job of programmes rather than having
a committee. As programmes are subject to change so frequently,
it is impossible for the Chairman to consult the whole commit-
tee on most of these changes, thus making the committee itself
superfluous.

A short list of papers that will be available for the forth-
coming session of the Winnipeg Medical Society is appended.

As the retiring Chairman, I would like to take this oppor-
tunity to thank publicly both the members of the Committee
and all those who have contributed to the programme during
the past year.

Respectfully submitted.

E. G. Brownell,
Chairman.

(1) Dr. Wm. McKinnon is willing to give a paper on
"Parachute Injuries." This, I understand, could also be
illustrated.

(2) Dr. F. Hartley Smith of the Great-West Life
Assurance Company would, if contacted early enough, be
prepared to give a paper on "Insurance Medicine." It is felt
that this latter would be very well received by the Society at
large.

(3) A double paper is available from the Department of
Anatomy, University of Manitoba Medical College, on "Con-

genital Absence of the Gall Bladder." Dr. D. J. Bowie and Dr. L. A. Sigurdson will both contribute to this presentation.

Legislative Committee of Fifteen

*To the President and Members of
The Winnipeg Medical Society:*

I beg to submit a report of the activity of the Legislative Committee of Fifteen for the term 1952-1953.

Some weeks ago rumor had it that certain changes in respect to the Basic Sciences Act and the Workmen's Compensation Act were being considered by the Government. Additionally, the C.P. & S. had drawn up rather extensive amendments to the Medical Act in an endeavour to consolidate it and to clarify certain sections.

Two meetings by the Legislative Committee were called, at which time the amendments to the Medical Act were presented and endorsement to these changes was given by the Committee. At the first of the two meetings consideration was given to the stand which the Committee would take in the event that definite action was to be taken in respect to the Basic Science Act and at the second meeting a small committee was struck to draw up a brief to present to the Law Amendments Committee.

As occurred on a previous instance two years ago, the Government saw fit to introduce such changes in legislation in the dying moments of the Legislature, allowing practically no time to contact any or all of the members of the Legislature before first and second reading to Bill 84, and Act to repeal the Basic Sciences Act, was given. Mr. Laidlaw had drawn a brief and this was presented by him but, despite that, third reading was given to the Bill and subsequently Royal Assent.

The following is a copy of the memorandum from Dr. M. T. Macfarland for your further information:

"The following bills were submitted for second reading to the Provincial Legislature on Friday evening, April 17th:

Bill 63 an Act to amend the Medical Act.

Bill 84, an Act to repeal the Basic Sciences Act, and

Bill 86, an Act to amend the Workmen's Compensation Act.

Bills 63 and 84 were referred to the Law Amendments Committee on Saturday morning, April 18th, at 11.00 a.m. Mr. T. W. Laidlaw presented a brief concerning the Basic Sciences (a copy of which has been addressed to each of the organizations represented on the Committee of Fifteen), no other representations were made, and the bills were reported.

The Bills were then considered by the committee of the whole House and reported for third reading which was given during the closing hours of the session on Saturday afternoon, April 18th.

Royal assent was given by the Lieutenant-Governor and the Acts are now effective."

No stand in respect to the Workmen's Compensation Act was made.

Respectfully submitted,

H. Funk,
Chairman.

Public Relations Committee

*To the President and Members of
The Winnipeg Medical Society:*

This Committee was established by the executive in February, 1953. Dr. Sigurdson and I have been doing this work for the Manitoba Medical Association for some years and will continue our association in affairs touching the Winnipeg Medical Society.

No problems have arisen in the past three months.

Respectfully submitted,

F. G. Allison,
Chairman.

Committee on Civil Defence Medical Services

*To the President and Members of
The Winnipeg Medical Society:*

In November, 1952, at the request of the President and with the advice of an advisory committee composed of the executive and members of the Winnipeg Medical Society this committee was formed and instructed to prepare plans to provide for medical service in the Greater Winnipeg Metropolitan Area in the event of a disaster.

Such planning is an integral part of Civil Defence planning in this city and across Canada and is made necessary by unstable nature of international politics in the world today. It is the earnest belief of Civil Defence planners in all branches that the organizations arising out of these plans can be equally useful in the event of civil disaster, such as fire or floods, as in the event of wartime disaster.

The committee is composed of Dr. J. L. Downey, Dr. F. Hartley Smith, Dr. J. T. MacDougall and Dr. A. R. Tanner, chairman. The committee has worked closely with Dr. Hugh Malcolmson, Provincial Director of Civil Defence Services and Medical Co-ordinator of Civil Defence Health Service for the Metropolitan Civil Defence Board of Greater Winnipeg, and with Major-General M. H. S. Penhale, Co-ordinator of the Metropolitan Civil Defence Board of Greater Winnipeg.

Doctors Downey and Smith attended the Western Regional Conference on Civil Defence Health Services in Edmonton in January and I attended the Eastern Regional Conference in Montreal in February. These conferences are held semi-annually under the chairmanship of Dr. K. C. Charron, Chief of the Civil Defence Health Planning Group in Ottawa and are attended by delegates from the provinces and target areas in the various regions across Canada. The purpose of these conferences is to review the developments in Civil Defence Health Planning at the Federal level, to integrate planning at the provincial and municipal levels and provide discussion amongst delegates of problems peculiar to individual areas. We found these conferences to be extremely interesting and instructive and of considerable help in setting out to make plans for the Winnipeg area.

In the organization of Civil Defence in an area such as Greater Winnipeg there is a branch for Civil Defence Health Services. This branch is headed by a Director of Civil Defence Health Services (Doctor Hugh Malcolmson) who is responsible to the Co-ordinator of Civil Defence (Major General Penhale). Under the Director of Civil Defence Health Services there are four branches, the Medical Services Branch, the Public Health Service Branch, the Special Weapons Branch and the Health Supplies Branch.

The Medical Services Branch is the branch which this committee is concerned with and is responsible for First Aid and Ambulance, Hospitals, Casualty Treatment, Casualty Evacuation and Medical Care on non Casualty Sick.

The foregoing has been a brief description of how and why this committee came into being, of how its members have become indoctrinated into some of the aspects of Civil Defence Health Planning and of what the committee is responsible for.

The following will be an attempt to report on how the committee has endeavoured to carry out its duties.

The first meeting of the committee was held during the first week in January and we have met weekly since and in the early phase of planning we met twice a week. The early meetings were long and much time was spent in developing ideas which were later discarded. Latterly with much of the ground work done we have conducted supper meetings with an hour or hour and a half business session following. I wish to thank the members of the committee for their faithful attendance at these meetings and the various members of the society whom we have asked at various times to attend these meetings. I also wish to thank Doctors Downey and Smith for

stenographic work which has been willingly done by their secretaries without recompense.

For the provision of Medical Services in the Greater Winnipeg area in the event of disaster the area has been divided into four sectors centred roughly on the junction of the Assiniboine and Red Rivers. The first sector is bounded by the Assiniboine River on the South, the Red River on the East and the C.P.R. yards and main line on the North East. The Second Sector is bounded on the South West by the C.P.R. yards and main line and on the East by the Red River. The Third Sector lies East of the Red River. The Fourth Sector is bounded on the East by the Red River and on the North West by the Assiniboine River.

The First Sector is the most heavily populated and the Winnipeg General Hospital has been designated as the parent medical unit for this sector. The Second Sector is less heavily populated and St. Josephs Hospital and Children's Hospital have been grouped to form the parent medical unit in this sector. The Third Sector is comprised of the population of Elmwood, East Kildonan, St. Boniface, Norwood and St. Vital, and St. Boniface Hospital has been designated as the parent medical unit for this sector. The Fourth Sector is comprised of the population of Fort Rouge, Fort Garry and River Heights and Grace and Misericordia Hospitals have been grouped as the parent medical unit in this sector.

In each sector the parent medical unit will be responsible for developing a disaster plan within its hospital or group of hospitals. A guide to such planning in the form of a Hospital Disaster Kit was issued to all Hospitals in Winnipeg by Dr. Malcolmson last summer. St. Boniface Hospital has been the first hospital to complete this kit, mainly through the efforts of Dr. Paul L'Heureux and the executive of the attending staff. Professional staff for completing the disaster plan in each parent medical unit are allocated by this committee and comprise the honorary attending staff and courtesy staff of the parent medical unit plus physicians known to live in the sector but with no close affiliation with any one hospital. Where a physician holds multiple staff appointments he will be given a choice of which sector he wishes to serve in. Physicians allocated to sectors but not required to complete the disaster plan of the parent medical unit may be used to staff other sector medical units such as First Aid Stations, Secondary and Emergency Improvised Hospitals. The disaster planning in the parent medical units provides for the allocation of nurses, orderlies and administrative staffs, the provision of emergency expansion of bed capacity, emergency operating rooms, etc.

First Aid Services are to be provided by the establishment of First Aid Stations around the periphery of the area of disaster. As we are living in the atomic age the disaster envisaged in a target area is the explosion of an atomic bomb and in the average Canadian city it is believed that such an explosion would result in approximately 20,000 surviving casualties. The Civil Defence Health Planning Group in Ottawa have developed a plan for a First Aid Station capable of providing First Aid for 1,000 casualties over a period of 24 hours. Roughly the personnel of such a station are 4 medical officers, 3 dentists, 6 registered nurses, 60 nurses aides and first aids, 50 stretcher bearers and clerks and transport personnel.

The committee initially undertook to plan for 20 such First Aid Stations but have reached the conclusion that a minimum of ten should be formed in the belief that in the event of an emergency they could be rapidly expanded to the required number. Civil Defence authorities at Federal, Provincial and municipal levels are deeply concerned over the organization of these First Aid Stations and are most anxious that training should get underway as soon as possible. Organization and training of these stations is important but is made difficult by the fact that the personnel are largely lay personnel. However the key personnel of the First Aid Stations are the medical officers and the Registered Nurses and without their initiative and co-operation successful organization and training is not possible.

The resources of the St. John's Ambulance and the Red Cross are available for assistance in training within the First Aid Station. The Federal Government have made available very complete First Aid Station training kits which contain all the instruments and materials required for complete and advanced first aid training. The Metropolitan Civil Defence Board through General Penhale are ready to provide every assistance possible in the way of publicity, buildings for training purposes and administration assistance.

One First Aid Station under the direction of Dr. Glen Hamilton and located at Lord Selkirk School in Elmwood is organized and has started training. A second First Aid Station under the direction of Dr. K. C. McGibbon is being organized at Canada Packers and a third and fourth will soon be organized in St. Vital and in the West End.

One of the major difficulties experienced by the committee has been to obtain volunteers amongst the members of the medical profession to undertake the direction of First Aid Stations.

Meetings and discussions have been held with Dr. Pat Riley who is Civil Defence Representative for the Winnipeg Dental Association and Mr. C. Chapman who is Civil Defence Representative of the Winnipeg Pharmaceutical Association and both of these associations are ready and willing to assist in the First Aid Station programme.

Under the direction of Dr. Malcolmson and Miss De Brinquet of the Provincial Department of Health and with the co-operation of St. John's Ambulance and the Red Cross continuous courses are being conducted in First Aid and Home nursing throughout the city and these trainees are encouraged to register for Civil Defence Duties so that they may become available for use in the First Aid Station training programmes.

In response to the interest shown by this committee in the development of First Aid Station training General Penhale has produced a very practical syllabus of training for the personnel of a First Aid Station based on his experience of training being carried out in other parts of Canada and the United States and of the probable situation arising out of a disaster such as an atomic explosion.

Twelve schools in Greater Winnipeg have been designated by General Penhale in conjunction with this committee for use as training centres for First Aid Stations.

In addition to completing plans for Parent Hospitals and First Aid Stations the committee in the future will have to develop plans for Secondary and Emergency Improvised Hospitals, designating suitable buildings for use as such and plans for Regional Hospitals and Assembly Points for personnel and supplies.

At both Regional Conferences members of the committee had the opportunity of observing First Aid Station demonstrations using Casualty Faking Technique for the production of very realistic casualties. This technique is very valuable for demonstration purposes and for advanced first aid training. At the conferences the casualty faking was done by a team under the direction of Major Bingham of Civil Defence Headquarters in Ottawa and Miss McLaren of the National Organization of St. John's Ambulance. A similar casualty faking team is working in Winnipeg under the direction of Mrs. Millidge of the St. John's Ambulance. The committee has been able to assist Mrs. Millidge in her work by putting her in touch with Major Alan Davidson, R.C.A.M.C., whose excellent colored photographs of war surgery in Korea have helped her team considerably in producing realistic casualties.

It is anticipated that in the fall of this year a public demonstration of Civil Defence activities will be put on in Winnipeg and it is hoped that the medical services will form an important and interesting part of this demonstration.

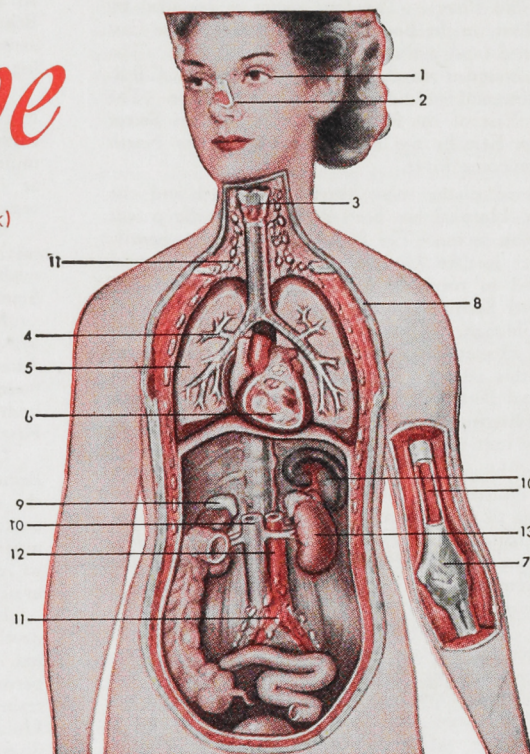
The committee wishes to suggest that the Winnipeg Medical Society through its executive undertake to appoint or allocate medical officers for duty with First Aid Stations. The Committee is ready to assist such medical officers in any way they can but have found the individual recruitment of medical officers for First Aid Stations to be an almost impossible task.

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†Transient beneficial effects.

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Finally, no report is complete without reference to finances. For the work of this committee there are no finances. We have applied to the Provincial Director and to the Metropolitan co-ordinator for assistance to provide or pay for secretarial help. Neither source was able to provide such help. We also asked them to pay all or part of the expense of our meetings. Again no help. We applied to the society for financial assistance and as yet they have not been able to provide any help. We feel that if the society can provide financial assistance for this committee either by itself or through its good offices from Provincial or Metropolitan sources, particularly for the provision of secretarial services it would greatly facilitate the work of the committee.

Again I would like to thank the members of the committee for their faithful support and record our appreciation of the co-operation received from Dr. Hugh Malcolmson and Major General Penhale.

Respectfully submitted.

A. R. Tanner,
Chairman.

Post Graduate Committee

To the President and Members of
The Winnipeg Medical Society:

As representative of the Winnipeg Medical Society to the Post Graduate Committee, I would like to submit the following brief report on the Refresher Course of the University of Manitoba Faculty of Medicine held in April of 1953.

As usual, a special April meeting was held in conjunction with the Refresher Course. We were very fortunate in hearing Dr. Hugh Morgan, Professor of Medicine of Vanderbilt University, speak on the "Chemotherapy of Bacterial Infections." Forty-eight practitioners attended this course. A financial report has not yet been worked out but there will be a loss. The attendance of Winnipeg Medical Society members and really of any Winnipeg practitioners was at a minimum. It has been suggested by the members of the Refresher Course Committee that it might be a good idea to obtain greater financial support both from the Winnipeg Medical Society and the General Practitioners' Association and then allow any city doctor who wished to attend free of charge.

Respectfully submitted.

E. G. Brownell,
Representative.

Report of Representative to Medical Library Committee

To the President and Members of
The Winnipeg Medical Society:

Forty-five per cent of the city's 581 physicians borrowed 1,200 books and 3,000 journals. During evening hours, from November to April inclusive, 58 doctors used the Library. There were seven library displays before meetings of the Winnipeg Medical Society with a member of the Library staff on duty.

With the one thousand dollars (\$1,000.00) grant of the Society, the Medical Library purchased 32 volumes, had 107 volumes bound, paid subscriptions to 6 periodicals and paid for student assistance during evening hours.

Respectfully submitted.

F. G. Allison,
Representative.

Representative to Executive Committee, Manitoba Medical Association

To the President and Members of
The Winnipeg Medical Society:

Your representative attended approximately 75% of the monthly meetings of the Manitoba Medical Executive during the past year.

The Canadian Medical Association Annual Meeting, scheduled for June of this year, in Winnipeg, naturally occupied a good deal of time and attention of the Executive.

The various sub-committees appointed to look after

arrangements have done their work well and the Convention should go smoothly.

The Association considered several proposals from different medical blocks regarding increase of fees and these were dealt with satisfactorily.

The long-drawn-out cold war with the Workmen's Compensation Board came to a very successful conclusion and, as a result, Manitoba physicians and surgeons now enjoy one of the highest and fairest schedules of Compensation Fees of any Province in Canada.

The Annual Convention, held last October, was voted possibly the best in local provincial history, both from the standpoint of attendance and quality of work presented.

The meetings, as a whole, continued to enjoy freedom from acrimony in debate and bitterness in discussion of controversial questions.

It was, all in all, in the opinion of your representative, a very good year.

All of which is respectfully submitted.

Jack McKenty,
Representative.

Welfare Council of Greater Winnipeg

To the President and Members of
The Winnipeg Medical Society:

The Health Division of the Welfare Council of Greater Winnipeg is made up of representatives from a large number of city organizations which are directly or indirectly concerned with the prevention, treatment, and the effects of disease. A series of informative and interesting meetings has been held throughout the winter and several worthwhile projects were carried out.

This was the first year of operation of the Logan Neighborhood House, which was opened last fall with a professional staff in charge.

A survey on social conditions in the Point Douglas area was made.

The need for a residential centre for Paraplegics and crippled children who are undergoing treatment in the city was thoroughly investigated at the request of the Kiwanis Club. It was agreed that there is a need for a residence for Paraplegic Patients, but that in the case of crippled children, foster homes may possibly serve the purpose. The problem in providing such a residence would not be the capital expenditure, but the yearly upkeep, and it was felt that at present there was no way of financing such a hostel. It is possible that funds might be available in the future through a Dominion-wide Rehabilitation Plan.

The pros and cons of Joint Health Drives were discussed, and a committee was appointed to study this question.

The Community Chest and Council of Greater Vancouver requested an endorsement of a Brief on Narcotics which they are submitting to the Hon. Paul Martin recommending an amendment to the Opium and Narcotics Drug Act, 1929. It was felt by the Health Division that this matter required further study, and it was decided to write to the Department of National Health and Welfare and endorse the establishment of a factual survey of drug addiction in Canada, and to request that the results of such a survey be made available to the Welfare Council of Greater Winnipeg. The Department was also to be requested to submit to the Welfare Council, for study, any proposed amendments to the Act.

Mr. K. O. Mackenzie, Deputy Minister of the Welfare Department, reported to the Health Division that a committee had been active during the last three or four months in an effort to co-ordinate and expand rehabilitation facilities in the Province. A national co-ordinator will be visiting Winnipeg in June.

Short reviews were presented at various times throughout the year of the work carried on by:

The Manitoba Association for Retarded Children.

The Committee on Alcoholism for Manitoba.

The School of Nursing Education.



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Respectfully submitted.

Marjorie R. Bennett,
Representative.

Community Chest Campaign Committee

To the President and Members of

The Winnipeg Medical Society:

At the request of your President, I took charge of collecting for the Community Chest from the doctors of Greater Winnipeg. The situation, as explained to me, was that a definite quota was given to the doctors and the responsibility of contacting the doctors was left to your Society. The quota was set at \$15,000.00, which was \$4,000.00 higher than last year. Cards were distributed to all the doctors through the captains of various districts. On assessing the returns, it was found that 317 doctors contributed \$10,905.00 and 180 doctors made no contribution. While not doubting the figures as supplied to me, many doctors claimed to have contributed through other groups as, for example, the Health Departments and the Department of Veterans Affairs, and some stated that they had made their contributions through their homes. This raises the question as to whether it is wise to have doctors collect from doctors. Failure to reach the objective can, perhaps, be charged to my inexperience in these matters.

In conclusion, I wish to state that we gave about \$600.00 more in 1952 than in 1951.

Respectfully submitted.

L. A. Sigurdson,
Chairman.

Representative to Manitoba Medical Review

To the President and Members of

The Winnipeg Medical Society:

The following is submitted as my report as representative of the Winnipeg Medical Society to the Manitoba Medical Review.

Monthly reviews of the Society's meetings have been inserted in the Manitoba Medical Review. This has necessarily been a form of a report of the programmes rather than a commentary on them. In addition, other newsworthy items have been published each month.

It has been very difficult to secure for publication the papers given at the various programmes. This has occurred partly because many of these have been in the form of round-table discussions rather than formal papers. Also, some of our visiting speakers have used only brief notes or lantern slides and had no prepared transcript of their talk which could be published.

The Manitoba Medical Review has relied rather heavily for original articles on the papers given at the Annual Manitoba Medical Association Convention each fall. Since there will not be a separate Manitoba Medical Convention this year, there will be nothing from this source in the way of original papers for the Review. It is, therefore, brought to the attention of the Society that original articles, either scientific or literary, and case reports by members of the Society and its sections will be very welcome during the coming year.

Respectfully submitted.

R. H. McFarlane,
Representative.

Representative to Manitoba Hospital Service Association

To the President and Members of

The Winnipeg Medical Society:

The Manitoba Hospital Service Association is now 14 years old, and about 42% of the population of Manitoba is covered by this voluntary prepayment of the cost of hospital care. 86.4% of earned income for 1952 was paid to cover hospital accounts. Operating expenses were 9.7%. A reasonable increase was made in the fund for epidemics, emergencies and pending maternity claims. All public Hospitals in Manitoba except one are under contract with M.H.S.A.

Coverage at Princess Elizabeth Hospital is now provided to the extent of \$5.00 a day toward the room charge and \$50.00 toward special services for up to 90 days of care including care in other hospitals for the same condition. Prior to accepting such claim in Princess Elizabeth Hospital, the patient is required to accept a rider to the contract excluding care for the condition for which admitted for the remainder of the life of the contract.

The Association was given authority to cover complications resulting from communicable diseases when properly attested by signature of the admitting doctor or medical superintendent of a member hospital.

Representatives of M.H.S.A. and M.M.S. met and discussed the need for better and closer relations between the two organizations.

In view of the increasing cost of dental care, which was not provided for in the contract and for which the rates do not make provision, the Association, after several conferences with the Dental Association, decided to revert to the strict wording of its contract and pay only for cases admitted to hospital by a duly qualified physician.

Respectfully submitted.

Marjorie R. Bennett,
Representative.

Representative to the General Practitioners' Association of Manitoba

To the President and Members of

The Winnipeg Medical Society:

A series of eleven executive meetings and three general meetings were held during the past year by the General Practitioners' Association of Manitoba.

The annual business meeting was held in October, 1952, during the time of the Manitoba Medical Association Convention. At this meeting the General Practitioners were fortunate in having as their guest speaker Dr. J. DeTar, of Milan, Michigan, voted Michigan's "Doctor-of-the-Year" in 1949. Dr. V. F. Bachynski was elected the Association's President for 1952-53 and, under his guidance, progress is being made.

A joint meeting of the Winnipeg Medical Society and the General Practitioners' Association of Manitoba, held in March of this year, was addressed by Dr. Gordon Wride of the Department of National Health and Welfare, Ottawa, and Dr. L. S. McMorris of Neepawa.

This is the second year such a joint meeting has been held and the hope is expressed that it may be an annual affair, as they appear to be popular.

A third general meeting, well attended, was held in late April, of this year, to discuss the question of partial closing of one of the Winnipeg Hospitals to its courtesy attending staff. Also at this meeting, members were asked to consider the question of lending support to the Section of General Practice of the Canadian Medical Association in their proposed formation of a College of General Practitioners of Canada.

The G.P.A.M. is presenting its fourth annual set of prizes to the year's outstanding internes, at the University Convocation on May 20th, 1953.

Summing up, the work of the G.P.A.M. marches along and its relations both to its parent body—the Manitoba Section of the C.M.A.—and its sister associations, continue to be harmonious.

Respectfully submitted.

Jack McKenty,
Representative.

Section of Anaesthesiology

To the President and Members of

The Winnipeg Medical Society:

The Anaesthetic Section of the Winnipeg Medical Society has held seven regular monthly meetings during the 1952-1953 term. An extra dinner meeting was held in November in honor of Dr. Harold Griffith of Montreal and Dr. Stanley



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Campbell of Toronto. The average attendance during these meetings has been 19.

The Annual Convention of the Manitoba Division of the Canadian Anaesthetists' Society was held in Winnipeg, February 25, 28, 1953. Dr. F. F. Foldes of Pittsburgh was a dynamic guest speaker and helped to make the meeting a resounding success. There were 41 registrants for the convention.

Respectfully submitted.

Ben Shell,
Secretary-Treasurer.

Eye, Ear, Nose and Throat Section

*To the President and Members of
The Winnipeg Medical Society:*

Four meetings of our section have been held in the past year.

The outstanding event of the year was the meeting held in October, at which Dr. Frank B. Walsh of Baltimore addressed the section.

Present membership of our Section stands at twenty-four.
Respectfully submitted.

W. C. Guest,
Secretary.

Section of Internal Medicine

*To the President and Members of
The Winnipeg Medical Society:*

The Section of Internal Medicine of the Society held two dinner meetings during 1952, at which the following papers were presented:

Dr. John Scott, Edmonton, Alta., "The Dublin School of Medicine."

Dr. L. G. Bell, Winnipeg, "Medical and Surgical Aspects of Splenic Dysfunction."

It is anticipated that a meeting will be held in May or June, 1953, at which time a new slate of officers of the Section will be elected for 1953.

Respectfully submitted.

A. E. Thomson,
Secretary.

Paediatric Section

*To the President and Members of
The Winnipeg Medical Society:*

We have to report some increase in the activity of this Section.

Professor A. L. Chute, University of Toronto, visited the city as an examiner for the examinations R.C.P.S. for certification in Pediatrics in October, 1952. A dinner was held at the Glendale Country Club. Following the dinner, Dr. Chute discussed several unusual and interesting case histories with the aid of lantern slides and pictures. An interesting discussion followed.

In April of 1953, Dr. F. J. McCreary, Professor of Pediatrics, University of British Columbia, was a guest speaker at the Refresher Course. He was entertained at a most enjoyable dinner at the Medical Arts Club Rooms.

There have been several short meetings of the Section to discuss various aspects of Pediatric Fee Schedules.

Respectfully submitted.

M. McLandress,
Secretary.

Radiological Section

*To the President and Members of
The Winnipeg Medical Society:*

Total membership for the year was 17, including members-elect and associate members. Two members left this province to practice elsewhere.

Three business meetings were held in the past year and two committees held more frequent discussions. It is felt that this section has had an active year within the group of divisions of the Winnipeg Medical Society.

Respectfully submitted.

M. K. Kiernan,
Secretary.

Benevolent Fund

*To the President and Members of
The Winnipeg Medical Society:*

I have pleasure in reporting a very useful and progressive year for the Benevolent Fund.

We have been able to lend financial assistance amounting to \$769.00 to members of our Society or their widows. This has been mostly helping out members who have been in temporary trouble owing to illness. In one case a member's widow with a small family was given a check for \$300.00 to help her get established in self support. This sum will probably be repaid. The Winnipeg Medical Society this year attached an appeal for the Benevolent Fund to your regular notification of dues.

In response to this appeal \$1,621.50 was collected.

We wish to thank the members of the Winnipeg Medical Society for their generosity in supporting this fund, and we hope to continue to report helpful work being done.

W. F. Tisdale,
Chairman.

Winnipeg, 6th May, 1953.

To the Members,
The Winnipeg Medical Society Benevolent Fund,
Winnipeg, Manitoba.

Dear Sirs:

We have examined the accounts of the fund for the year ended 30th April, 1953, and submit herewith our statement pertaining thereto:

Balance, 30th April, 1952	\$2,040.09
Add: Receipts for the year	1,621.50
Bond Interest	45.00
	<hr/>
	\$3,706.59
Less: Disbursements	769.00
	<hr/>
Balance, 30th April, 1953	\$2,937.59
Represented by:	
Cash on deposit with the Bank	
of Toronto	\$1,471.34
Government of Canada Bonds, 3%, 1966,	
Par Value \$1,500.00 (Market Value	
\$1,398.75) Fully Registered in name	
of Fund—at cost	1,466.25
	<hr/>
	\$2,937.59

Donations received are in accordance with duplicate receipts examined by us. All disbursements made were under the signatures of authorized signing officers of the fund.

The bank balance is in agreement with a certificate received from the bank. The securities have been placed in a safety deposit box and were presented for our examination. All interest has been accounted for on a received basis.

Yours very truly,

THORNTON, MILNE & CAMPBELL,
Chartered Accountants.

remember ...

triple **ANTI HISTAMINE**



thepryl | Chemical competition

desoxyephedrine | Stimulation of the sympathetic

atropine | Inhibition of the parasympathetic

thepryl
COMPOUND | for the histamine basis of allergy

CAPSULE THEPRYL COMPOUND 25 mg.
Each capsule contains:
Thepryl (Chlorothenylpyramine Citrate) 25 mg.
Desoxyephedrine Hydrochloride 0.625 mg.
Atropine Sulphate (1/2000 gr.) 0.032 mg.

CAPSULE THEPRYL COMPOUND 50 mg.
Each capsule contains:
Thepryl (Chlorothenylpyramine Citrate) 50 mg.
Desoxyephedrine Hydrochloride 1.25 mg.
Atropine Sulphate (1/1000 gr.) 0.064 mg.

OINTMENT THEPRYL COMPOUND
Thepryl (Chlorothenylpyramine Citrate) 2%
Calamine 10%
Zinc Oxide 5%
Camphor-Phenol 1%
Benzocaine 1%

Also available
THEPRYL EXPECTORANT SYRUP and CAPSULE

Thepryl Reg'd Trade Mark for
Chlorothenylpyramine Citrate

 **CHARLES R. WILL & CO. LIMITED • LONDON • CANADA**
ETHICAL PHARMACEUTICALS

College of Physicians and Surgeons of Manitoba

Registration Committee—Feb. 23, 1953

Enabling Certificates Deferred

Wolodymyr Krywulak, M.D., Lwow U., 1944.
Victor Zaitzeff, M.D., l'Aurore U., 1947.

Enabling Certificates Granted (if certain conditions fulfilled)

Vincent Vesin Chen, M.D., St. John's U., Shanghai, 1934.
Ivan Thomas Beck, M.D., U. Geneva, 1949.
Min Kun Kwong, M.D., U. Paris, 1930.
Wu Lou, M.D., l'Aurore U., 1941.

Certificates of Registration Deferred

Albert Leonard Nowell, L.R.C.P., Edinburgh, 1945; L.R.C.S., Edinburgh, 1945; L.R.F.P.S., Glasgow, 1945.
Robert Murray Holmes, L.M.S.S.A., London, 1946.
James McCartan, L., L.M., 1940, R.C.P. Ireland; L., L.M. 1940, R.C.S. Ireland.
Cyril Hamwee, M.B., Ch.B., Victoria U., Manchester, 1939; M.R.C.S., England, 1939; L.R.C.P., London, 1939.

Certificate of Registration Confirmed

William Leslie Parker, L.R.C.P., Edinburgh, 1951; L.R.C.S., Edinburgh, 1951; L.R.F.P.S., Glasgow, 1951.

Certificates of Registration Granted

James Marshall Gillies, L.R.C.P., Edinburgh, 1947; L.R.C.S., Edinburgh, 1947; L.R.F.P.S., Glasgow, 1947.
Lionel Francis Gilbert Cruickshank, M.B., Ch.B., U. Edinburgh, 1945; D.A., R.C.P., England, 1951.

Registration Committee—March 9, 1953

Enabling Certificate Deferred

Gregor Bronstein, M.D., l'Aurore U., 1935; M.D., Aix-Marseille U., 1940.

Enabling Certificates Granted

Herbert Benno Lang, M.D., U. Innsbruck, 1945.
Maire Marjatta Halinen, D.M., U. Helsinki, 1939.
Wolodymyr Krywulak, M.D., Lwow U., 1944.
Lorant Ferenc Kocsis, M.D., Royal Hungarian Elizabeth U., 1944.
Victor Zaitzeff, M.D., l'Aurore U., 1947.

Certificates of Registration Deferred

Albert Leonard Nowell, L.R.C.P., Edinburgh, 1945; L.R.C.S., Edinburgh, 1945; L.R.F.P.S., Glasgow, 1945.
James McCartan, L., L.M. 1940, R.C.P. Ireland; L., L.M. 1940, R.C.S. Ireland.
Robert Murray Holmes, L.M.S.S.A., London, 1946.
Cyril Hamwee, M.B., Ch.B., Victoria University of Manchester, 1939; M.R.C.S., England, 1939; L.R.C.P., London, 1939.

Certificate of Registration Granted

Cramond Christie Wright, M.B., Ch.B., U. Aberdeen, 1939; D.P.H., U. Aberdeen, 1947.

Certificate of Licence Granted

Jerzy Jozef Jan Tadeusz Klimczynski, M.B., Ch.B., Polish School of Medicine, Edinburgh, 1946; M.D., Polish School of Medicine, Edinburgh, 1949.

Executive Committee

March 11th, 1953.

A combined meeting of the Legislative and Executive Committees was held Wednesday, March 11, 1953, in the Medical Arts Club Rooms.

Present—Legislative Committee: Dr. W. J. Boyd, Chairman, Dr. A. R. Birt, Dr. S. S. Toni.

Executive Committee: Dr. C. B. Stewart, Chairman, Dr. Ed. Johnson, Dr. C. H. A. Walton, Dr. A. R. Birt.

Dr. C. E. Corrigan, President, Mr. T. W. Laidlaw, Solicitor, and Dr. M. T. Macfarland, Registrar.

1. Business Arising From Minutes of Council Meeting October 11, 1953

A. Amendments to the Medical Act

The Solicitor presented the prepared amendments to the Medical Act as per the copies on file. Several minor changes were suggested, and after detailed consideration of the amendments, the following motion was passed.

Motion: "THAT the amendments to the Medical Act be accepted, and that the Solicitor be instructed to submit them to the present session of the Legislature." Carried.

Mr. T. W. Laidlaw and members of the Legislative Committee withdrew.

B. Registrars' Meeting

The Registrar advised he had arranged to hold the meeting of the Registrars on Thursday, June 18, 1953.

Motion: "THAT the Registrar be authorized to attend the meeting of the Registrars and arrange for a luncheon." Carried.

C. Community Chest and Council of Greater Vancouver

The Registrar presented the following report of the Committee to study request of Community Chest and Council of Greater Vancouver for the support of its proposed amendments to the Opium and Narcotic Drug Act.

To: The Executive Committee, Manitoba Medical Association, and The Council, College of Physicians and Surgeons of Manitoba.

As requested by the Council of the College of Physicians and Surgeons of Manitoba in annual meeting, October 11th, 1952; and Executive of the Manitoba Medical Association meeting, November

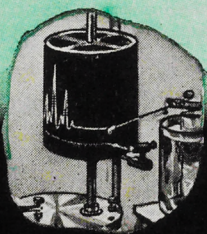
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for superior spasmolysis...

Donnatal[®]



Employs natural belladonna alkaloids, in optimum standardized proportions,* for relief of gastrointestinal, urinary, biliary or uterine spasm. Prescribed by more physicians than any other spasmolytic.

* Each Donnatal Tablet or Capsule contains hyoscyamine sulfate 0.1037 mg., atropine sulfate 0.0194 mg., hyoscine hydrobromide 0.0065 mg., phenobarbital (1/4 gr.) 16.2 mg.



A. H. ROBINS COMPANY OF CANADA LIMITED
Montreal, Quebec, Canada

16th, 1952, a Committee composed of Doctor W. F. Tisdale, representing the Manitoba Medical Association; Doctor C. E. Corrigan, representing the College of Physicians and Surgeons; Doctor M. T. Macfarland, in his capacity of Registrar, College of Physicians and Surgeons, and Executive Secretary of the Manitoba Medical Association; and myself as Chairman, was set up to study the request received from the Community Chest and Council of Greater Vancouver, concerning its proposed amendments to the Opium and Narcotic Drug Act.

Your Committee met on January 15th, 1953, and had for consideration a copy of the brief submitted to the Honourable Paul Martin by the Community Chest and Council of Greater Vancouver, and confidential information received from the Narcotic Division of the Department of National Health and Welfare. Members of the Committee previously had an opportunity to hear Mr. A. M. Shinbane, Q.C., solicitor for the Narcotic Division, address the Manitoba Medico-Legal Society on the problem of drug addiction.

Your Committee is agreed that:

1. Drug addiction presents a very complex problem.

2. That changes in the Opium and Narcotic Drug Act should be considered only on the basis of well authenticated information.

Your Committee is informed that the Department of National Health and Welfare considers setting up a fact-finding committee to study the present problem of drug addiction in Canada, and that this committee will include a competent research worker.

Your Committee recommends:

1. That the Executive of the Manitoba Medical Association and the Council of the College of Physicians and Surgeons of Manitoba endorse the establishment by the Department of National Health and Welfare, of the factual survey of drug addiction in Canada.

2. That the Department of National Health and Welfare be requested to make available to the Executive of the Manitoba Medical Association and the Council of the College of Physicians and Surgeons of Manitoba, the results of such survey.

3. That the Department of National Health and Welfare be requested to submit to the Executive of the Manitoba Medical Association and Council of the College of Physicians and Surgeons of Manitoba, for study, any proposed amendments to the Opium and Narcotic Drug Act, 1929.

Respectfully submitted,

Edward Johnson, M.D.,
Chairman.

January 16, 1953.

The Registrar advised that the Executive of the Manitoba Medical Association had accepted the brief. He also advised a request had been received

from the Welfare Council of Greater Winnipeg requesting that the brief be made available to them, and the Committee agreed to this.

D. General Medical Council of Great Britain Re Internship Requirement

The Registrar presented a list, prepared by the G.M.C., of the approved hospitals and institutions and recognized house officer posts in England and Wales, Scotland, Northern Ireland, and the Republic of Ireland, and advised that similar lists were being prepared for other Commonwealth countries.

Communication From the Medical Registration Council, Dublin, Eire

The Registrar presented a communication dated January 27th from the Medical Registration Council, Dublin, advising that by virtue of the provisions of the Medical Practitioners Act, 1951, all newly qualified medical men and women will be required to serve as internes in an approved hospital or hospitals for a period of twelve months, and that there was complete reciprocity between the General Medical Council and the Medical Registration Council, Dublin; and inquiring concerning hospitals and our reciprocal agreement with the General Medical Council. The Registrar also read his reply.

E. Cancer Relief and Research Institute

At the last Council meeting the Registrar was instructed to take up the problem of radium lists with the Medical Advisory Committee of the Cancer Institute. The decision was taken at the meeting of the Board, December 8, 1952, to obtain competent legal opinion as to the effectiveness of the Institute's power to restrict the use of its radium, before any further action is taken.

F. The Canadian Doctor Re Fee Splitting

The Registrar presented the February, 1953, issue of the Canadian Doctor containing the article on fee splitting.

G. Salaries

Motion: "THAT Miss Jean Allison and Miss Lorna Zawadzki be given an increase in salary of Fifteen Dollars (\$15.00) per month each, retroactive to January 1, 1953." Carried.

2. Report of Committees

A. Registration Committee

(a) Dr. _____

It was agreed that Dr. _____ file be placed in the hands of the solicitor for all future correspondence. (Refer minutes of Registration Committee, March 9, 1953).

(b) Dr. _____

It was agreed that Dr. _____ file be placed in the hands of the solicitor for his opinion. (Refer minutes of Registration Committee, March 9, 1953).

(c) Dr. _____

When Dr. _____ appeared before the Registration Committee on March 9th, there were

discrepancies between his verbal and written statements concerning his internship, and he was requested to supply a notarized statement concerning his work since graduation, and the Registrar was instructed to obtain a verbal report from Dr. Dr. notarized affidavit stated he was admitted to the Royal College of Physicians and Surgeons in Dublin, Ireland, July 5, 1940; attended Mercer's Hospital, Dublin, as an interne for the three years continuously prior to his graduation; was in private practice in Dublin for one year after graduation, during which time he attended Mercer's Hospital; was in private practice during 1941 to 1950 in Sheffield; practised for one year at Brooks, Alberta, and was registered with the College of Physicians and Surgeons of Alberta; and practised at Nipawin, Saskatchewan, for two years, and was registered with the College of Physicians and Surgeons of Saskatchewan. The Registrar outlined his telephone conversation with Dr.

Motion: "THAT the ten years in general practice, and registration in the Provinces of Alberta and Saskatchewan, be taken as evidence of medical competency, and a Certificate of Registration be granted to Dr." Carried.

B. Discipline Committee

Motion: "THAT a letter be written to the Minister of Health explaining that Dr. did not qualify under the regulations of the College, and investigation caused considerable delay." Carried.

(a) Dr.

The Chairman of the Discipline Committee reviewed the correspondence with Dr. and the Division of Narcotic Control, and advised that Dr. name will be placed on the "Restricted List." The Committee agreed that no further action could be taken, but Dr. should be offered every assistance.

(b) Dr.

The Registrar presented a communication from Hospital for Mental Diseases, Brandon, dated January 16, 1953, advising that Dr. was admitted to the hospital on October 6, 1952, was probated on December 18, 1952, and was discharged outright as from January 15, 1953. The Committee agreed that no further action be taken

C. Gordon Bell Memorial Committee

For information of the Committee, the Registrar presented a communication dated February 6th, from Dr. Colin Ferguson, present recipient of the Gordon Bell Fellowship, advising it was necessary for him to leave the United States prior to March 1st, unless he was willing to serve 2 years as a medical officer in the United States Army, although there was the possibility that he would be

able to return as a visitor to the United States and finish his term at the Children's Hospital, Boston, once he established his residence in Canada. He requested his Gordon Bell cheques be held until he learned whether he would be returning to the States or not.

3. Correspondence

A. Communication From the Canadian Medical Association

The Registrar presented a communication, dated November 14, 1952, from Dr. C. W. Burns, President-Elect, Canadian Medical Association, requesting a donation from the College of Physicians and Surgeons of Manitoba, to the Canadian Medical Association, re the expenses of entertainment during the annual meeting of the C.M.A. which will be held in Winnipeg during the week of June 15th. He advised that at the time of the last C.M.A. meeting in Winnipeg in 1947, the College of Physicians and Surgeons and the Manitoba Medical Association each donated \$1,000.00, and the Winnipeg Medical Society \$500.00. A small deficit of only \$324.51 was incurred, and the C.P. & S. absorbed this amount, and the donations of the M.M.A. and W.M.S. were returned intact.

Motion: "THAT the College of Physicians and Surgeons of Manitoba donate the sum of One Thousand Dollars (\$1,000.00) to the Canadian Medical Association to be used for entertainment during the Annual Meeting of the Canadian Medical Association in Winnipeg in June." Carried.

B. Communication From Mrs. W. G. Campbell

The Registrar read a communication dated January 8, 1953, from Mrs. W. G. Campbell, acknowledging the floral tribute for the late Dr. W. G. Campbell.

C. Request for Change of Name

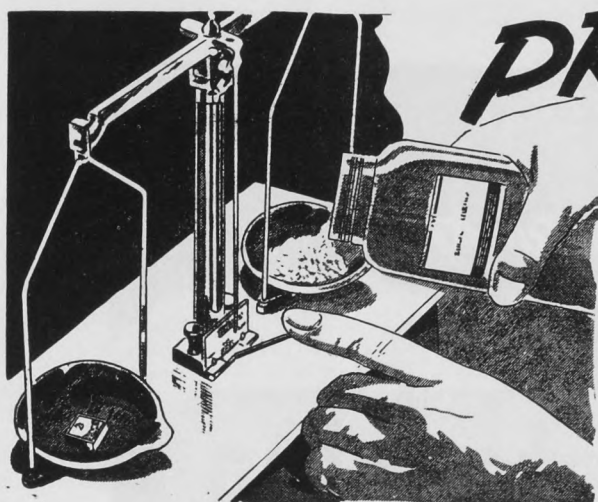
The Registrar presented a communication dated December 19, 1952, from Dr. Enid E. Morrison, requesting her name be changed on the records of the College to her married name, McRuer. Her Marriage Certificate under date of June 18, 1949, was presented.

Motion: "THAT the name of Enid Elizabeth Margaret Morrison be changed to Enid Elizabeth Margaret Morrison McRuer on the records of the College of Physicians and Surgeons of Manitoba." Carried.

4. New Business

A. Date of Council Meeting

The Committee agreed that unless it was necessary, the special meeting of Council not be held, but if a meeting is required before October, it should be called in June. This matter was left to the discretion of the Chairman of the Executive Committee.



PRECISION!

Precision is the guiding principle in filling prescriptions at EATON'S.

All prescriptions are compounded and filled accurately and scientifically by fully qualified pharmaceutical chemists. Each prescription is then double checked for the patient's protection.

EATON'S prescription department represents an outstanding example of quality, accuracy, and service; the prime factors in the reliable dispensing of medicinal ingredients.

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LACTOGEN

a powdered all-milk formula closely approximating breast milk

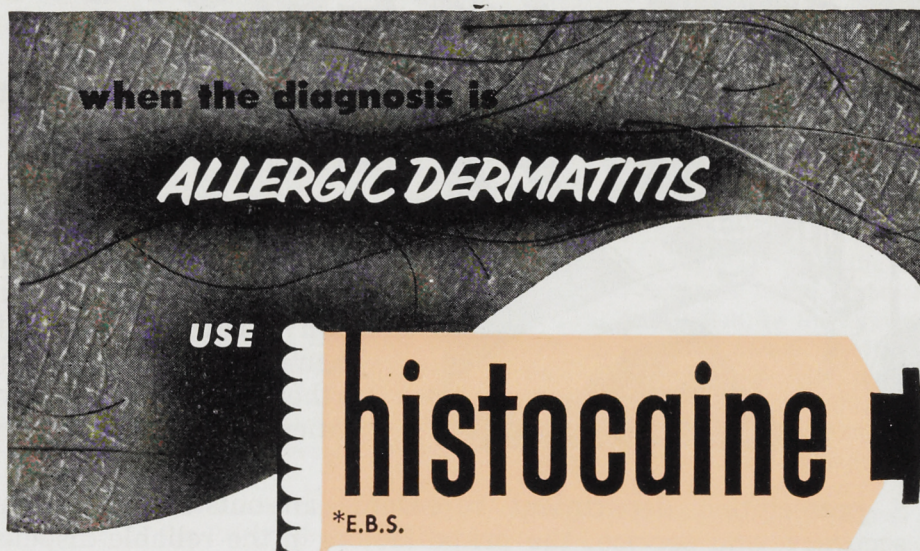
Lactogen is a natural all-milk formula consisting of whole cow's milk modified with milk fat and milk sugar. It contains no milk substitutes.

Closely approximating the composition of breast milk in other factors, Lactogen, however, provides a one-third more liberal allowance of protein.

Lactogen is prepared simply by stirring into warm, previously boiled water. It is made up with equal ease, either for a single feeding or for an entire day's use.

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Histocaine E.B.S. is the ointment of choice because it may be safely used for treating a wide range of skin conditions, both systemic and local. Its ingredients are such as to provide the following actions: relief from itching, reversal of allergic manifestation, local anaesthesia, antiseptis. The water-soluble base is easily removed, literally dissolving in a stream of water. Histocaine does not soil clothing.

HISTOCAINE CONTAINS: Camphor, Menthol, Calamine, Benzocaine and Pyranisamine Maleate in a water-soluble base.

INDICATIONS: Burns (thermal & solar), insect bites, poison ivy, contact dermatitis, allergic pruritus, and allergic skin reactions in general.

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AN ALL CANADIAN COMPANY . . . SINCE 1879

Representative: Mr. S. M. Fairclough, 542 Ingersoll Street, Winnipeg

Department of Health and Public Welfare Comparisons Communicable Diseases — Manitoba (Whites and Indians)

DISEASES	1953		1952		Total	
	June 14 to July 11, '53	May 17 to June 13, '53	June 15 to July 12, '52	May 18 to June 14, '52	Jan. 1 to July 11, '53	Jan. 1 to July 12, '52
Anterior Poliomyelitis	64	3	1	2	93	3
Chickenpox	115	95	173	87	799	833
Diphtheria	1	—	1	—	4	2
Diarrhoea and Enteritis, under 1 yr.	14	16	6	8	63	63
Diphtheria Carriers	—	—	—	—	—	—
Dysentery—Amoebic	—	—	—	—	—	—
Dysentery—Bacillary	2	—	1	—	5	12
Erysipelas	2	2	2	2	22	9
Encephalitis	1	1	—	—	2	1
Influenza	21	19	4	19	180	112
Measles	93	114	165	179	2214	838
Measles—German	2	9	2	1	35	11
Meningococcal Meningitis	1	4	1	2	21	10
Mumps	96	73	76	103	748	826
Ophthalmia Neonatorum	—	—	—	—	—	1
Puerperal Fever	—	—	—	—	—	1
Scarlet Fever	24	36	64	74	263	436
Septic Sore Throat	1	2	3	6	22	53
Smallpox	—	—	—	—	—	—
Tetanus	1	—	—	—	1	1
Trachoma	—	—	—	—	—	—
Tuberculosis	65	67	100	70	465	452
Typhoid Fever	—	1	—	—	1	—
Typhoid Paratyphoid	—	—	—	—	—	—
Typhoid Carriers	—	—	—	—	—	—
Undulant Fever	2	3	—	1	6	3
Whooping Cough	9	8	24	114	75	311
Gonorrhoea	104	76	105	104	589	690
Syphilis	13	5	10	9	50	67
Infectious Jaundice	28	19	2	3	184	27
Tularemia	—	—	—	—	1	3

Four-week Period June 14th to July 11th, 1953

DEATHS FROM REPORTABLE DISEASES

For the Month of June, 1953

DISEASES (White Cases Only)	*798,000 Manitoba	*861,000 Saskatchewan	*3,825,000 Ontario	*2,952,000 Minnesota
*Approximate population.				
Anterior Poliomyelitis	64	12	94	88
Chickenpox	115	258	1274	—
Diarrhoea & Enteritis, under 1 yr.	14	19	—	—
Diphtheria	1	—	—	1
Diphtheria Carriers	—	—	—	—
Dysentery — Amoebic	—	—	—	5
Dysentery—Bacillary	2	—	2	17
Encephalitis Epidemica	1	—	—	—
Erysipelas	2	3	1	—
Influenza	21	—	10	8
Jaundice, Infectious	28	15	36	100
Measles	93	259	1209	207
German Measles	2	167	152	—
Meningitis Meningococcus	1	4	8	8
Mumps	96	106	750	—
Ophthal. Neonat.	—	—	—	—
Puerperal Fever	—	—	—	—
Scarlet Fever	24	12	210	23
Septic Sore Throat	1	2	1	15
Smallpox	—	—	—	—
Tetanus	1	—	—	—
Trachoma	—	—	—	—
Tuberculosis	65	61	118	172
Tularemia	—	—	—	—
Typhoid Fever	—	1	3	5
Typh. Para.-Typhoid	—	—	2	—
Typhoid Carriers	—	—	—	—
Undulant Fever	2	—	3	21
Whooping Cough	9	22	40	10
Gonorrhoea	104	—	138	—
Syphilis	13	—	56	—

Urban—Cancer, 77; Influenza, 2; Lethargic Encephalitis, 1; Measles, 2; Pneumonia, Lobar, 1; Pneumonia (other forms), 3; Pneumonia of Newborn, 1; Poliomyelitis, 3; Tuberculosis, 4; Infectious Hepatitis, 1. Other deaths under 1 year, 27. Other deaths over 1 year, 223. Stillbirths, 19. Total, 269.

Rural—Cancer, 39; Influenza, 1; Lethargic Encephalitis, 1; Measles, 1; Pneumonia, Lobar, 3; Pneumonia (other forms), 6; Pneumonia of Newborn, 1; Tuberculosis, 5; Diarrhoea and Enteritis, 2. Other deaths under 1 year, 23. Other deaths over 1 year, 217. Stillbirths, 19. Total, 259.

Indians—Cancer, 1; Measles, 1; Pneumonia, Lobar, 1; Pneumonia (other forms), 2; Tuberculosis, 2; Syphilis, 1. Other deaths under 1 year, 5. Other deaths over 1 year, 5. Stillbirths, 2. Total, 12.

The chief point of interest is that at date of writing (July 27th) we are again in the midst of a polio epidemic. To date 300 cases have been reported — including six deaths. The majority of cases are in the Greater Winnipeg area and about two out of three show some degree of paralysis. In epidemic areas gamma globulin is being given to household contacts within certain age limits, of paralytic cases. Careful records are being kept so that we may evaluate its use in Canada. No charge is made for this gamma globulin as Canada and its provinces have pooled their funds to make it available.

Detailmen's Directory

Representing Review Advertisers in this issue, whose names are not listed under a business address.

Abbott Laboratories

G. J. Bowen	44 559
R. G. (Bud) Harman	507 509
Bruce Hunter	42 5263

Allen & Hanburys Co.

H. W. Heaslip	31 405
E. M. Tackaberry	404 184

Ayerst, McKenna and Harrison

W. R. Card	407 115
C. G. Savage	34 558
C. W. Smith	724 231
R. A. E. Perrin	424 703

Borden Company Ltd.

Geo. Williams	87 697
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British Drug Houses

F. J. Burke	38 413
W. B. Pipes	935 802

Ciba Company Ltd.

Fred Ruppel	422 769
Stan W. Phillips	727 367

Cow & Gate

R. J. Clarke	50 7150
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Connaught Laboratories

Brathwaites Ltd.	922 635
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Frosst, Chas. E.

W. M. Loughheed	403 963
W. J. McGurran	208 231
E. R. Mitchell	402 132

Horner, Frank W. Limited

Jos. Errenberg	590 558
Ross Mackay	61 244
Linc. Sveinson	57 141

Mead Johnson

George Moore	405 815
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Merck & Co.

W. G. Ball	45 702
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Park, Davis & Co.

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B. S. Fleury	404 441

Poulenc Limited

W. J. Plumpton	526 585
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Sandoz Pharmaceuticals Ltd.

H. D. Robins	39 936
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Schering Corp. Ltd.

Halsey Park	404 346
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Schmid, Julius

W. H. Davis	206 941
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G. D. Searle & Co.

Harry Chambers	506 558
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Shuttleworth, E. B.

S. M. Fairclough	30 158
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Squibb & Son, E. R.

MacArthur, J. H. Don	404 741
M. G. Waddell	504 744

Swift Canadian Company

H. A. Plant	209 833
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Will, Chas R.

John R. Hope	401 883
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Winthrop-Stearns

Geo. Edmonds	49 744
R. M. Kelly	34 580

Wyeth & Bro., John

A. W. Cumming	35 271
W. J. Tarbet	423 495

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Nurses' — 722 151	Sundays and
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Practical Nurses.	Phone 722 008

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Brandon, Manitoba

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- A medical eye examiner (Eye Physician, M.D.) can tell whether you really need glasses, or treatment for some health condition that is affecting your eyes.

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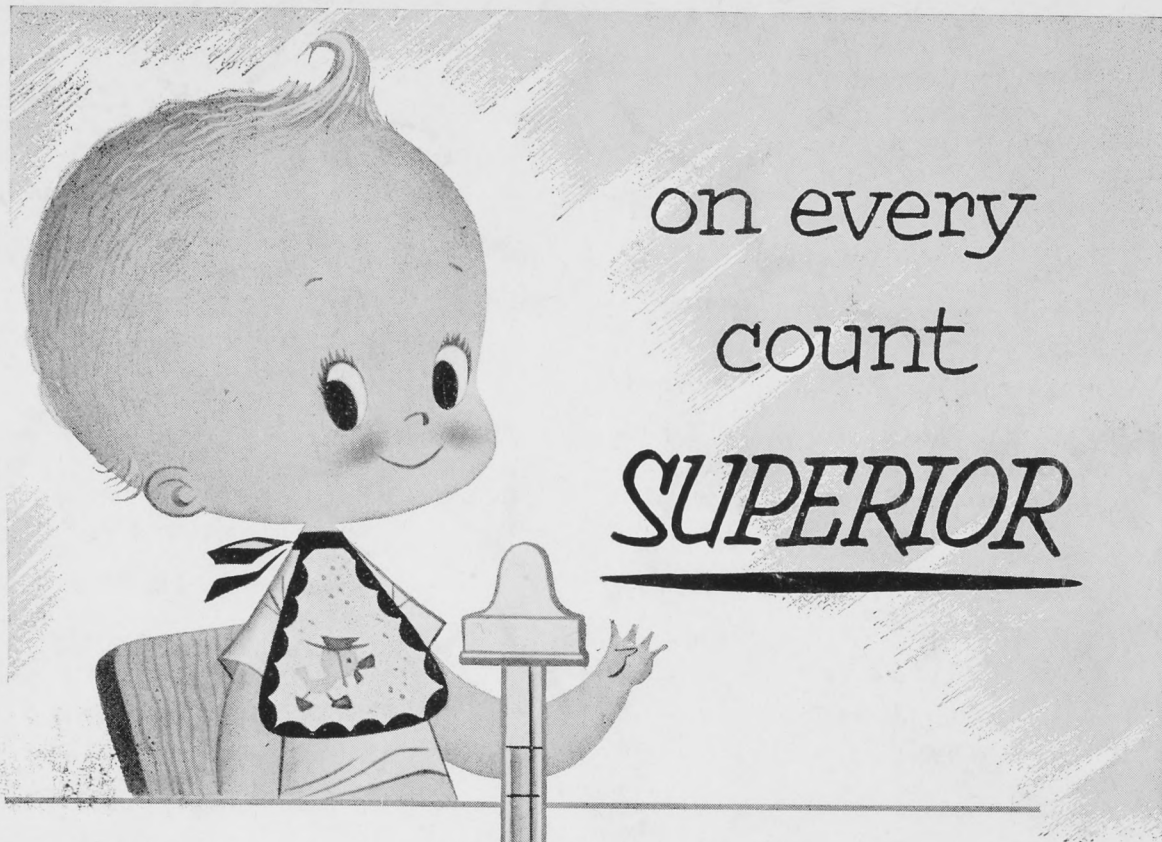
Qualifications: Must have at least four years' experience as a bacteriologist in a recognized public health laboratory, must be a capable administrator, have considerable knowledge of pathology and bacteriology. A diploma in Public Health desirable.

This is a permanent position carrying all Civil Service benefits.

Salary Range: \$7,080.00 - \$7,680.00 per annum, depending on qualifications.

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Vitamin A	5000 units
Vitamin D	1000 units
Ascorbic acid	50 mg.
Thiamine	1 mg.
Riboflavin	0.8 mg.
Niacinamide	6 mg.

When a supplement containing just vitamins A, D and C is desired, specify Tri-Vi-Sol . . . also superior in patient acceptability, convenience and stability.

Superior flavour

Pleasant-tasting. No disagreeable aftertaste. Readily accepted without coaxing.

Superior miscibility

Disperses readily in formula, fruit juice or water. Mixes well with cereals, puddings or strained fruits.

Superior convenience

Light, clear and non-sticky . . . can be accurately measured and easily administered. No mixing necessary . . . in ready-to-use form.

Superior stability

Requires no refrigeration. May safely be autoclaved with the formula.



POLY-VI-SOL

MEAD

MEAD JOHNSON & CO. OF CANADA, LTD.
Belleville, Ontario

Local Representative: George Moore, 494 Niagara St., Winnipeg, Man.